

***Medical Law for the
Dental Surgeon***

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Medical Law for the Dental Surgeon

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Medical Law for the Dental Surgeon

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*to
family
and
friends*

Preface

“What does law have to do with dentistry or for that matter, medicine?” was the common refrain I heard from friends and colleagues when I told them about this book. A fair enough response, considering that doctors and lawyers traditionally worked at two ends of the professional spectrum. Law has a bearing on virtually all aspects of life. Medical science is no exception. The influence of law on the medical profession has greatly increased in the last few decades, thanks to a lay society that has found itself questioning the medical profession like never before. However, this is not the only reason. Many aspects of medical advancement have attracted legal and ethical scrutiny. This in turn has resulted in numerous legislations to protect the doctors, patients and the public at large. The Human Organ Transplantation Act, Medical Termination of Pregnancy Act and the Prenatal Diagnostic Techniques Regulation Act are some of the recent legislations brought on to reign in nefarious medical practices. Medical law has emerged today as a full fledged specialty dealing with a variety of areas like professional negligence, doctor-patient contracts, consumer protection laws, ethics, general and special health legislations, practice regulatory mechanisms, human rights, genetics and a host of other issues.

Medical law and ethics affect dentists in a manner similar to the way it affects other medical specialties. This book deals with some of these general aspects in addition to some special problems faced by dentists. The cases discussed and examples are from dental situations as far as possible to allow the reader to relate to the problem.

Medical legislations that have no bearing on the dental specialist have been avoided to keep the book focused on issues the dentist is likely to face in his daily practice. Legal issues and laws concerning the hospitalized patient have also been dealt with superficially. Maxillofacial surgeons may need to look elsewhere to satisfy their requirements.

The chapter on forensic odontology is only meant as a primer. It is not an exhaustive discussion on forensic techniques. However it will give the dentist a peep into this exciting new field and a working familiarity with the specialty. It will hopefully inspire a few to pursue the field as well.

Dentists (including me) are famously oblivious of taxation laws. It is important that dentists have a working knowledge of these laws.

With the insurance sector opening up in India, dentists may have to deal with insurance companies on a more regular basis in their practice. A familiarity with the topic might come in handy.

I hope the reader will find this unusual book a useful one and enhance his knowledge of legal issues that might have a bearing on his/her profession.

George Paul

Foreword

Medical Law for the Dental Surgeon is a very informative book. Medical professionals including dental surgeons are often ignorant about the laws governing their profession. Few dentists are familiar about the Dentist's Act 1948 and the functions of the Dental Council. The author has attempted to give simple explanations of various laws and legal issues affecting dentists.

Dr. George Paul is an experienced postgraduate teacher of dental surgery and also holds degree in law. He also has a postgraduate degree in medical law and ethics from the prestigious National Law School of India University, Bangalore. He has extensively dealt with the subject of law, rendering easy to understand definitions of legal terms and vocabulary. Dr. Paul has covered a wide range of subjects including, the Dentist's Act, Consumer Protection Act, dental negligence, informed consent, civil and criminal liabilities of dentists, evidentiary requirements, insurance, responsibilities to HIV patients, taxation laws affecting dental professionals and dental ethics. The chapter dealing with quantification of dental deformities will be particularly useful to dentists dealing with medico-legal cases. There is also a chapter on forensic odontology, which is a new and emerging field for dental surgeons with a curiosity in the subject.

The case reports on decided cases in consumer courts and civil courts are very interesting and illustrative of the different kinds of negligence.

The book is elaborate and informative, and will serve as a handbook and table reference for every dentist in his or her day-to-day routine. It is a must read for every practicing dentist.

I sincerely wish that teaching institutions would strongly recommend that their students read this book before they start their 'Rotatory Internship.'

My congratulations to Dr. George Paul for authoring such a book in the interest of the profession.

Dr. VM Veerabahu
National President
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Acknowledgements

Legal issues in dentistry being a new field, I had to tap resources from various specialists in law, medicine and dentistry.

I wish to thank my teachers in 'TILEM' (The Institute of Law and Ethics in Medicine) at the National Law School of India University, Bangalore who introduced me to the world of legal medicine. I have extensively used their course material pertaining to Law and Ethics in Medicine. In particular I wish to name Prof SV Joga Rao former faculty at TILEM and Prof SS Allur who is the present co-coordinator of TILEM.

I wish to thank Dr. J. Ranganathan, the State Secretary of the IMA, Tamil Nadu who made available to me numerous references pertaining to legal issues in medicine.

I acknowledge with thanks the encouragement I received from the dental fraternity Dr. VM Veerabahu former Hon. National Secretary IDA and current President of the IDA was a source of immense encouragement. He not only agreed to write the foreword but also read through the manuscripts and made valuable suggestions. He supplied much of the information on eradication of quackery.

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There have been numerous friends and colleagues who have contributed to this book, sometimes even without knowing that they were doing so. To them my profound thanks.

I am deeply indebted to my parents Dr. G. Paulose and Mrs. Achamma Paulose who inspired me to take dentistry as a vocation and my parents-in-law Mr. SP Thomas and Mrs. Achamma Thomas who encouraged me to pursue law as an additional degree.

My wife Dr. Achamma Bini George and my two children Deepti and Divya have been a constant source of inspiration to me.

To all these benefactors named and un-named I dedicate this book.

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Chapter 1

Introduction to Law as Relevant to Dental Surgeons

WHAT IS LAW?

Since the concept of law consists of various ingredients, no single definition can cover all the ingredients. In a general sense it can be said that law consists of rules governing the conduct of man in a civilized society and that which is enforceable by a court of law. In its most simplistic form Law may be defined as “an aggregate of rules enforceable by judicial means in a given country”.

Law influences every aspect of human life from birth to death and even beyond death. Law helps to regulate human activity in society. Medicine and dentistry are no exceptions. To understand some fundamental concepts of law one must understand some basic terminologies and have an insight into the evolution of law in human social life.

HISTORY OF LAW

Law is a dynamic concept, which constantly changes and evolves depending on new rules and regulations. Law is not an end in itself but a means towards regulation of human activity and governance.

Legal systems existed in all ancient civilizations from Sumerian to Babylonian to Roman civilization.

Early Indian laws were first recorded in the Laws of Manu (c.1500 BC). Like many ancient legal systems it was essentially theological and emphasized on social norms and rituals in life and death. The caste system played an important role in the kind of punishments for different crimes.

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The Vinaya or the Buddhist monastic codes are another ancient legal system.

Kautilya's Arthashastra (c 250 BC) outlined the power of the sovereign in addition to laws of marriage and forms of agreement. It also prescribed punishments for various crimes.

Modern law in India began with the Charter Act of 1627, which enabled the English to exercise jurisdiction over fellow English citizens.

Mayor's courts were first established through the Charter Act of 1687, with courts in Madras, Bombay and Bengal. Numerous reforms came into force through Lord Warren Hastings, Lord Cornwallis, and others. By 1858 India came directly under the British Queen. With this the 3rd Law commission, Indian High Courts Act 1861 and Indian Councils Act came into force. The Indian National Congress came into being in 1885. By 1935 the Indian Independence movement gained momentum.

The Government of India Act 1935 gave provincial autonomy and a Federal Court was established in Delhi for appeals from High Courts. Previously, all appeals went to the Privy Council in England.

India became independent through the Independence Act in 1947 and one year later all appeals to the Privy Council was abolished.

The present Constitution came into force on January 26th 1950

Law, Legality and Justice

In a strict sense **law** may be said to be a set of rules, recognized and enforced by the courts in the administration of Justice.

Acts done in accordance with law may be referred to as **legal** as opposed to **illegal**.

Justice may be said to be a standard of action, of and on the part of public officials in accordance with the entire body of law.

SOURCES OF LAW

Where Does Our Law Come from?

Laws basically are derived from 3 sources:

1. Legislation (Statute laws)
2. Court made law or un-codified law
3. Custom as a source of law

Legislation (Statute Law)

Legislation is the formal enactment of law by the legislature authorized by the constitution. This is the written law or *Leges Scriptae*. It is also called the codified law.

The constitution of India is the fundamental law of India. It defines not merely the structure and function of Government, but also enumerates fundamental rights of individuals. The constitution of India was drafted by a drafting committee of the constituent assembly under the chairmanship of Dr.B.R.Ambedkar and was adopted on November 26, 1949.

The full text came into force on January 26, 1950 when India became a Republic. The constitution consists of 443 Articles, divided into 26 parts and 12 schedules. As a democracy the sovereign power is vested in the hands of the people. The constitution clearly indicates the organization, power and function of the three limbs of the Government.

- The executive power of the union is vested with the **President**.
- The legislative power lies with the **Parliament**.
- The judicial power lies with the **Supreme Court**.

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The legislature or parliament enacts or amends laws, the president executes them and the judiciary interprets the laws. In a parliamentary form of government, the executive power (the President) is only a nominal authority.

GOVERNMENT FUNCTION

The constitution has outlined the distribution of power in the VII schedule to the constitution.

At the apex is the central government followed by 25 state governments. The state government has control over the organization of local self-government within the state.

The administrative machinery is divided among the following 3 levels of Government.

1. **Central government** (Central list)—Defence, foreign affairs, banking currency, etc., only the central government legislates in the above areas.
2. **State government** (state list)—Police, local government, health, sanitation, agriculture, etc. The state as well as central government can legislate upon these powers.
3. **Concurrent powers** (Concurrent list)—Criminal law, criminal procedure, indecency, Trust/Trustees. Both the state and central government can legislate on these. In the event of a conflict the central law will prevail.
4. **Residuary powers**—(powers not dealt with in the above) is vested in the central government.

The central legislative is called the parliament and it has two houses the upper house or **Rajya Sabha** and the lower house or **Lok Sabha**. The Rajya Sabha (elected from the state legislative assemblies) has 250 members (MPs) including those nominated by the President. The Lok Sabha has 550 members (MPs) elected by the people.

These two houses have the powers to enact laws in accordance with the provisions of the constitution.

Similarly, each state has a state assembly consisting of members of the legislative assembly (MLAs) who are elected by the people of the state and their numbers vary from state to state. Some states have a legislative council as well.

Both houses of parliament have the primary power to enact laws in accordance with the provisions of the constitutions. Likewise the state government enacts laws binding on the state.

Local bodies and administrative bodies also enact laws within their jurisdiction by the power vested in them as a sub-ordinate authority. The validity of the laws passed by the legislature can be questioned in any court of law only if the law has violated any of the provisions of the constitution or fundamental rights of citizens.

1. The advantage of legislated law is that they can legislate in advance.
2. It can legislate on any subject within its competence.
3. It can with exceptions over ride the law laid down by courts (It cannot modify or reverse decisions)
4. It is not subject to appeal (although it can be declared void or invalid by courts of law if found unconstitutional).

Examples of legislations relevant to the medical/dental field are:

1. Dentists Act 1948 (central legislation)
2. The Consumer Protection Act 1986 (central legislation).
3. The Tamil Nadu Private Clinic Establishment Act 1997 (state legislation).

Common Law or Judicial Law (uncodified)

As different from legislated law or codified law these are Judge made laws. These flow from judicial decisions. Courts and judges often have to make decisions that are not covered

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by legislated law. These decisions or rulings become law unless struck down or amended by a higher court.

When a higher court gives a judgment, deciding a question of law, it is reported in the law reports. A future judge faced with the same question of law will use the legal proposition emanating from the previous judgment. This is the principle of **precedent** becoming a source of law.

In India the law laid down by the Supreme Court is binding on all lower courts and authorities. They can supercede the law made by lower courts such as High Courts or district courts.

A large portion of Indian law, like the Law of Torts, is governed by common law (Jus commune) or Judge made laws.

In addition to laws that are made by judicial decisions, the courts also play an important role in interpretation of legislated law when the language, grammar or intent of a legislated law is unclear and open to interpretation. This is called judicial review or interpretation.

Examples of judge made laws relevant to dentistry are:

1. Prohibition of smoking in public places. (Supreme Court of India and some State High Courts).
2. Prohibition of sale and consumption of 'Gutka' (Supreme Court).

Classification of Law

It is impossible to have a comprehensive classification of law due to its complex nature. Simple divisions however help us understand the nature of law.

I. *It can be classified as:*

1. **Private law**—Deals with legal relation between individuals or groups of individuals, e.g. law of contracts. An engineer X makes a contract with doctor Y to service his X-ray equipment for one year for a fee.

2. Public law—Deals with powers of the state or authority and the relationship between individuals and the state like in Constitutional Law, Administrative Law and International Law, e.g. Legislation prohibiting smoking in public places.

II. Another Classification is based on the nature of laws.

1. Civil law—They deal essentially with the rights and duties of individuals or groups of individuals and are dealt with in civil courts. Civil courts provide relief of civil wrongs done to individuals or corporations in the form of compensation or specific performances as in Torts or Contracts, e.g. civil negligence of a doctor/ dental surgeon resulting in complications like fracture of a jaw following extraction.

2. Criminal law: Cases where an act is done against society and the remedy for which is penal in nature come under criminal law. The prosecutor is usually the state (e.g.) a rash and negligent dental procedure resulting in death of patient. For instance the failure of a dentist to recognize and treat a syncope resulting in shock and possible death.

Procedural and Substantative Law

Substantative law is the law relating to rights and duties, e.g. Indian Penal Code (1860), Indian Contract Act (1872), The Human Organ Transplantation law (1998) and Dentists Act (1948). The Dentists Act 1948 lays down the rules relating to dental qualification, years of study, registration and other rules.

Procedural law deals with the means of obtaining legal remedy. They outline the procedural aspects of the law process. They deal with the procedures to be adopted in the operation of Law, e.g. Criminal Procedural Code (CrPC) and Civil Procedure Code (CPC).

COMMONLY USED WORDS AND PHRASES

Jurisprudence

Jurisprudence deals with essential principles of law and legal systems. It deals with nature of legal rules, underlying meaning of legal concepts and essential features of legal systems. Medical Jurisprudence deals with principles and concepts pertaining to medicine and health.

Statute

An “Act” passed by the legislature and assented to by the President of India or Governor of a state. Statutes are of following kinds:

- Declaratory—which merely explains.
- Remedial—which confers a right/favour
- Amending—which alters the existing statutes.
- Consolidating—which amalgamates existing statutes.
- Codifying—which reduces the prevalent customs and/ statutes to one set of rules.

Bill

A “Bill” is a draft form of law moved or to be moved before Parliament or State Legislature. A bill when passed by Parliament becomes an “Act”

Ordinance

“Ordinance” is the law promulgated by the President of India during the recess of parliament under Article 123 of the Constitution of India. Any Ordinance is a temporary measure passed by the President under his legislative powers though such power has to be exercised based on the advise of the Council of Ministers.

Suit

Any legal proceeding of a **civil nature** brought by one person against another is called a “Suit”.

Jurisdiction

Jurisdiction refers to the place where a suit can be instituted. Generally, a suit may be instituted in a court within the local limits of whose jurisdiction.

- a. Defendant resides; or
- b. Any of the defendants reside (where there are more than one defendant), with the permission of the court; or
- c. Cause of action wholly or in part arises, subject to satisfaction of the Court. Cause of action is the event that necessitated the filing of the suit.

Jurisdiction of courts and Tribunals maybe understood in the following manner:

1. Original Jurisdiction
2. Appellate Jurisdiction

For instance a claim for compensation in a consumer case against a dental surgeon in Salem (District head quarters) may be instituted before State Commission in Chennai in case the claim amount is Rs. 5 lacs or more because such a claim will fall under original jurisdiction of State Commission, Tamil Nadu. In case the claim is for less than Rs. 5 lacs, such a claim will be adjudicated before District Forum in Salem. But an appeal may be filed before the State Commission in Chennai, which will hear the appeal under its appellate jurisdiction.

Jurisdiction may also be seen from the angle of location of the parties and also amount of claim involved. They are referred to as:

1. Location jurisdiction or territorial jurisdiction [depending on place of incident or residence of plaintiff (complainant) or defendant].
2. Pecuniary jurisdiction (on the basis of Money involved).

Where cause of action for filing a complaint arises in Maharashtra and the opposite parties are also residing in Maharashtra such a case cannot be instituted outside

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Maharashtra. If a doctor in Maharashtra has treated a patient in Maharashtra, a complaint alleging medical negligence cannot be instituted in Gujarat on the ground that the patient has later shifted to Gujarat. This is referred to as locational jurisdiction.

Pecuniary jurisdiction is the pecuniary limit (based on the quantum of compensation claimed) of the court. For instance pecuniary jurisdiction of District Forum is upto Rs. 5 lacs. State Commission has pecuniary jurisdiction upto Rs. 20 lacs and pecuniary jurisdiction of National Commission is unlimited.

Judgment

The adjudication by a court of law may be either a “Decree” or an “Order”. Decree is the formal expression of adjudication so far as the court expressing it conclusively determines the rights of the parties with regard to all or any of the matters, which forms the subject matter of the suit.

Summons

Summons is the process of court asking the opposite party to an action to appear and answer the claim preferred by the party who has brought the action (Order V of Civil Procedure Code).

Warrant

A “Warrant” is issued by a Court and directed to a police officer (Secs. 70 & 72 of Criminal Procedure Code). In judicial process, it is a writ issued by a Magistrate/ Competent Judicial Authority authorizing any officer to make arrest, seizure or search or to do any other act incidental to the administration of justice.

Warrant Case

A warrant case is a case relating to an offense punishable with death, imprisonment for life or imprisonment for term exceeding 2 years.

Summons Case

A summons case is a case relating to an offence, and not being a warrant case.

Cognizable Offence

An offence in respect of which a police officer may arrest without a warrant in accordance with first schedule of the code of Criminal Procedure Code or under any law in force. E.g. Rash and negligent medical/dental act resulting in death is a cognizable offence (s. 304 A). Death on a dental chair is usually liable under criminal law as a cognizable offence.

Non-Cognizable Offence

An offence in respect of which a police officer has no authority to arrest without warrant (Criminal Procedure Code 1973). For example, simple injury following a dental procedure like pain and swelling after extraction.

Bailable Offence

An offence shown as bailable in the first schedule or which is made bailable by any other law for the time being in force. Cr.P.C. Sec. 2 (a). They can be set free on furnishing a bond or on the guarantee of the arrested person or some prominent citizen that he will be available for investigation. (S.304a is bailable). Bail can be demanded as a matter of right. The arresting police officer has to show reasons why he will not grant bail. The reason has to be valid and real, for instance the apprehension that he may commit more criminal acts or that he may leave the country.

Non-Bailable Offence

An offence other than bailable offence [Code of Criminal Procedure Sec. 2(a)]. Certain capital offences require the accused to be in custody by nature of the offence and founded apprehension that he may jump bail or tamper with evidence.

Complaint

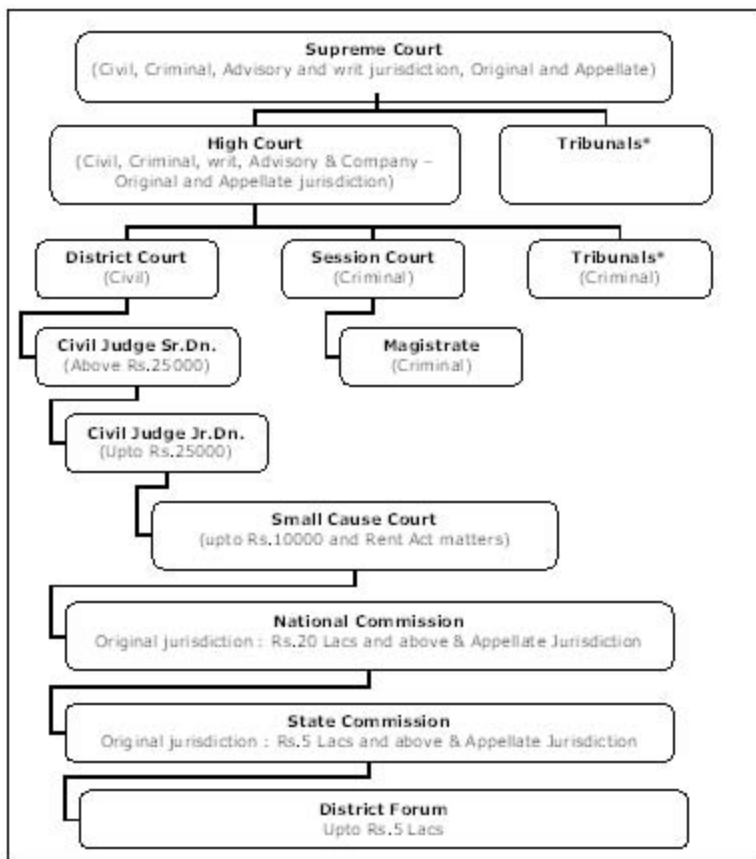
Any allegation made orally or in writing to a magistrate, with a view to his taking action, that some person, whether known or unknown has committed an offence, but does not include a police report.

Writs

Both the Supreme Court and High Courts have Writ Jurisdiction. In other words they are entitled to declare a law as a nullity and quash/set aside any unlawful/unconstitutional orders, violating/abridging /restricting fundamental rights. These writs are called writs of:

- I. **Habeas Corpus**—a writ or direction against unlawful arrest and detention.
- II. **Mandamus**—a writ against unconstitutional or unlawful administrative order, etc. It can be used against officials of the government.
- III. **Certiorari**—a writ or direction issued by a higher court to a lower court or tribunal directing that the records of the case be sent to itself for re-determination.
- IV. **Prohibition**—a writ or direction issued by a higher court forbidding the lower court or tribunal from hearing a case brought before it on the ground of lack of jurisdiction.
- V. **Quo-Warranto**—a writ or direction directing an authority to explain by what warrant or authority he/she holds the said position.

HIERARCHY OF COURTS



* For instance **Consumer Forum** is a tribunal with following hierarchy (A three tier system) and an Appeal from the order of National Commission lies only to Supreme Court.

Chapter 2

Interface of Law and Dentistry

IMPORTANT STATUTORY LAWS WITH RELEVANCE TO THE MEDICAL/DENTAL PRACTITIONER

Under the authority of the constitution, a number of laws have been framed to regulate and control various aspects of health and health administration, health education and public health policy.

Health is an issue of National importance and the Directive Principles of State Policy have given direction to the implementation of health programmes that will benefit all the citizens of the country. Although right to health is not a fundamental right, it has been brought into the broad ambit of the Right to life and personal liberty, (Article 21).

Some of the important statutes relating to health are given below:

CENTRAL LEGISLATIONS RELEVANT TO PUBLIC HEALTH

Drugs and Cosmetics Act 1940

It regulates the import, manufacture, distribution and sale of drugs and cosmetics.

It deals with all drugs used for treatment, diagnosis or prevention of disease in man and animals. All drugs used in dentistry should be regulated by the above Act. *In some countries, dentists and doctors have restrictions on the drugs that they can prescribe depending on the type of practice they are involved in. In India there is no separate Dental Formulary for drug prescriptions.*

Environmental Laws in India

Environmental issues have been dealt with in many Acts passed by the centre in the last 15 to 20 years.

The Public Liability Insurance Act

It pertains to accidental harm caused by hazardous substance and the need for liability insurance to be taken out by the persons storing or handling hazardous substances that can cause harm. It was legislated in the wake of the Bhopal gas tragedy.

It is important for dentists to keep this act in mind while storing hazardous substances in their clinics or storerooms. *A Dental Surgeon can be held liable for harm caused to the public by inadvertent exposure of harmful substances like mercury, arsenic or for that matter even radiation.*

- Water Pollution Act—1974
- Air Pollution Act—1982
- Environment Pollution Act—1986

The above Acts have relevance particularly in the context of medical waste disposals. *Dentists must understand their duties in the context of the above Acts, when disposing bio hazardous wastes such as blood, gauze, infected material, sharps and clinic drainage.*

Epidemic Disease Act 1925

It calls for compulsory notification of all epidemic diseases. Dentists as health providers are bound by it. *Please note that HIV testing is voluntary and not mandatory. The patient's rights are protected from being reported except in special situations under special authorization. This aspect will be dealt with in detail elsewhere.*

Narcotic Drugs and Psychotropic Substances Act 1985

It repeals archaic laws such as the Opium Act 1875 and Dangerous Drugs Act 1930.

Many drugs such as sedatives, tranquillizers and narcotic analgesics come under this Act. *Dentists must be careful in dealing with them, as misuse can invite stringent punishment.*

Poisons Act 1919

It regulates possession of poisons for sale use or importation.

Many substances such as Arsenic, which are used in dentistry, are regulated by this Act. Possessions of large quantities have to be regulated by the state government.

Dentists Act 1948 (Amended in 1962)

This is an important act regulating the training and practice of dentistry in India. It will be dealt with in details elsewhere.

Medical Council Act and Other Related Acts

In addition to the The Medical Council Act 1956, other relevant Acts include, Pre-Natal Diagnostic Technique Act 1994, Mental Health Act 1987, Medical Termination of Pregnancy Act 1971, Maternity Benefits Act 1961, The Human Organ Transplantation Act 1998 etc., As these Acts are not directly relevant to dental surgeons, they are not described in detail in this book.

Some Acts of possible importance include The Indian Medical Degrees Act 1916 and Drugs and Magic Remedies Act (objectionable advertisements) 1954. The former has application in containing quackery and the latter has been used by medical associations to combat unethical and

grandiose advertisements by qualified and unqualified practitioners.

Criminal and Civil Laws

The Indian Penal Code 1860, Code of Civil Procedures 1908 and Criminal Procedure Code 1973 all deal with various aspects of law relating to doctors and dentists like civil public nuisance and criminal offences relating to public safety, spread of diseases, pollution of water and air, etc.

Statutes Regulating Medical Practice in States

Many states in India have state legislations to regulate establishment and running of private medical/dental establishments. For example, the Tamil Nadu private medical establishment Act 1998. Other states having legislations are Karnataka, Goa and Delhi.

How is Health Laws Legislated?

Health legislation consists of statutes, which shape the way that health policy is translated into health programmes and services. This is as much relevant to dental health, as it is to any other field of health.

Health legislation is also important in public health and evolution of health policy.

Health legislation prohibiting conduct injurious to health, e.g. the ban on public use of tobacco and gutkha. This was effected due to intense lobbying by many dental organisations.

Health legislation has been used to authorize programmes and services, e.g. Government dental health programmes like free dental check ups and free tooth powder scheme in Tamil Nadu.

Health legislation for social financing of health care. Dental health insurance is available in many western countries. It will soon be a reality in India as well. The common man can have access to medical/dental treatment by taking out insurance policies.

Health legislation establishing surveillance of quality of care. Today dental surgeons are not bound by any authority. Very few legislations such as the Tamilnadu Private Clinics Act and the Karnataka Private Medical Establishment Act 1998 have authority. *There will be a need to legislate laws to oversee not only quality of treatment but also the observance of ethical standards in dental practice.*

Law is relevant to all aspects of life. Medical science is no exception. Medical and dental education, services, practice, hospitals and public health are regulated by law.

Many of these laws are statutes made by parliament, State Governments, and other bodies authorized by the constitution.

The Medical Council and Dental Council are autonomous bodies formed to regulate and supervise medical and dental education through universities which lay down basic standards of education.

The maintenance of Indian Medical Register and State Medical and Dental Registers by every state Medical and Dental Council facilitates enrolment procedure and a supervisory mechanism. The Act has given it powers to make regulations and codes. Ayurveda, Siddha and Unani are governed by the Indian Medicine Control Council Act 1970.

The Dental Council further enacted the Dentists Code of Ethics Regulations in 1976 in pursuance of the powers entrusted to the Dental Council of India.

The Dental Council Act and the Code of Ethics will be discussed in the next chapter.

Chapter 3

Dentists Act of 1948: Salient Features

The Dentists Act, 1948 was passed as the 16th Act of 1948 in Parliament session and is the binding legal document for the dental profession and dental education in India. Several amendments were passed after that. However, there are several areas where the Act needs to be modified and updated, keeping in mind the tremendous progress of dentistry and dental education in India. The Act provides for the formation of the Dental Council of India and the State Dental Councils. The Dental Council of India has the following functions:

1. Regulation of dental education and training in India.
2. Recognition of dental qualifications from India and abroad.
3. Recognition of para-dental courses such as dental hygienists and dental mechanics.
4. Power to acquire information from any authority, which grants a dental degree—the details of the study, training and examinations.
5. Inspection of institutions and centers providing recognized dental training programmes.
6. Professional conduct of dentists and the code of ethics for dentists.
7. Maintain a register of dentists called the Indian Dentists Register consisting of the entries of all the State Registers of Dentists.
8. Power to make regulations with the approval of the Central Government to manage the functions of the Council and to prescribe the standard curricula for training of dentists and dental hygienists/mechanics.

The Dental Council of India has the following members:

- a. Registered Dentists elected from each state.
- b. One Member elected from among the members of Medical Council of India.
- c. 4 members elected from among the Principals, Deans and Vice Principals of recognized Dental Colleges.
- d. One member from each university which grants a recognized dental qualification
- e. One member nominated by the State Government.
- f. 6 members nominated by the Central Government of which 2 shall be dentists registered in Part-B of the State Register.
- g. The Director General of Health Services

The Council's members then elect the Executive Committee from among themselves and also the Vice President and President whose tenure is for a period of 5 years.

The list of dental qualifications recognized by the Dental Council of India is as given in the schedule with Part-1, Part-II and Part – III of the Dentists Act. These schedules can be updated every time when a new institution or University or qualification is approved by the Dental Council of India and the Government of India.

State Dental Council

Each State in the country constitutes the State Dental Council. The State Dental Council consists of the following:

- a. 4 members elected among themselves by dentists registered in Part- A of the State Register.
- b. 4 members elected among themselves by dentists registered in Part-B in the State Register.
- c. The heads of recognized dental colleges.
- d. One member elected from among themselves by the members of the State Medical Council.

- e. 3 members nominated by the State Government.
- f. The Chief Medical Officer of the State.
- g. The President and Vice President of the State Council are elected by the members from among themselves.

The most important constitution of the State Council is maintaining a register for qualified dental surgeons, dental hygienists and dental mechanics with details such as the full name of the person, nationality, residential address, qualification, professional address and date of his first admission in the register.

The fee is collected by the State Council on an annual basis from the members. The person's name can be removed from the State Register if

- i. his name has been entered in the register by error or on account of misrepresentation or suppression of a material fact, or
- ii. he has been convicted or any offence or has been guilty of any infamous conduct in any professional respect (or has violated the standards of professional conduct and etiquette or the code of ethics prescribed under section 17A) which in the opinion of the (State) Council renders him unfit to be kept in the register (or)
- iii. he having been permitted temporary registration under clause (b) of sub-section (2) of section 34 has, on such registration, been found to practise the profession of dentistry for personal gain (only foreign nationals).

A foreign national who possesses the recognized dental qualifications can be registered in the State Council after getting permission from the President of Dental Council of India for purposes of teaching and research but not for personal gain. The person registered in a particular State may practice in any other state. The council has powers to punish unqualified person from using the description of dental practitioners, dentists, dental surgeon, dental

hygienist or dental mechanic or using an abbreviation indicating the dental qualification.

No court shall take cognizance of any offence punishable under this Act except upon complaint made by the State Government or the State Council.

FAQs

What laws governed a dentist prior to the Dentists Act?

There were no statutory laws to govern dental practice or education before 1948. In fact any body could practice dentistry. There was no university degree awarded in dentistry prior to the 1950's. Dental colleges in Mumbai, Calcutta and Lahore awarded the 3 or 4 year licentiate courses. The course was well structured and conducted by a board. These licentiates were later recognized as Part A qualification and many licentiate holders went on to do BDS and MDS after passing a special examination conducted by the universities after the Act came into force.

Why have the Dental Council laws not been amended to phase out the Part B representation in DCI as their numbers are reduced now?

Sadly the Dental Council has not amended the representation from Part A and Part B dentists. The proportion of Part A dentists is many times that of Part B dentists but in states like Tamil Nadu they have four representatives each in the state council. This lopsided representation should be corrected by appropriate amendments. The Dentists Act is awaiting amendments before the parliament. Reliable sources claim that it may take some time due to the pending bills and amendments in the parliament.

Is the fellowship from the UK Royal Colleges recognized as postgraduate qualification in India?

The FDSRCS (also FFDRCS) of all the colleges in the United Kingdom and Ireland are recognized by the Dental Council and are registrable postgraduate degrees.

By what criterion does the DCI recognize foreign undergraduate and postgraduate qualification?

The qualifications are recognized as individual cases based on the curriculum, transcripts, and other criteria. On application the details of these foreign institutions are placed before the Council and approved if found adequate. It is good practice to find out from the DCI regarding recognition before joining a foreign institute for post-graduation.

Can the DCI take punitive action against any dentist? Has it ever been done?

In theory the State and Central Dental Councils can take punitive action by striking out the names from the rolls etc. In practice this happens rarely.

Chapter 4

Doctor-Patient Relationship

Strictly speaking the doctor-patient relationship is a contractual relationship. It cannot, however, be simplified into a purely business relationship. The doctor traditionally has certain special obligation to his patients in particular and to society in general. This has been emphasized from ancient time as is evident from the Oath of Hippocrates (460 B C). Legal and ethical concepts governing negligence, informed consent and confidentiality are therefore bound and influenced by this special relationship.

Changing Doctor-Patient Relationships

Talcott Parsons a social scientist theorized that “illness was a type of dysfunctional deviance and required reintegration with the social organism.” According to Parsons the doctor’s role was to set right this deviance. The doctor and patient were protected by “emotional distance”. In his opinion, doctors through their training and by popular social expectation were conditioned to rise above normal social beings. His intentions were expected to be altruistic and egalitarian (service above self and material gain). We all know that this is a desirable relationship, but the reality is far from the truth. Today the doctor is guided by various other considerations. Apathy and disregard to the poor, disadvantaged and terminally ill (particularly with diseases such as AIDS and Hepatitis B), are a fall out of this shifting relationship. Similarly doctors are less sympathetic to patients who have diseases that the doctor feels have been brought on by the patient himself. For example, obesity, lung cancer, AIDS etc. This, in the author’s opinion is particularly true of dentists. There is a reluctance to treat

when there is apprehension of complication, transmission of infection or poor financial returns. Under these circumstances society questions the special status and legal privileges demanded by doctors. The doctors on the other hand may argue that these attitudes are a fall out of a litigative society that does not appreciate the circumstances it works in. The situation is quite like that of the problem of 'what came first, the chicken or the egg?' The misplaced suspicion and ill will between doctor's and patients are largely due to this change in societal perceptions.

We have already mentioned that the doctor-patient relationship is a type of contract.

Sewa Ram vs Dr V. Guptha. 1999(1) CCC152.(Pg 6)
"There is a great deal of commercialization of the medical profession and service. Polyclinics, diagnostic centres and nursing homes have come up in markets, in commercial centres and even in residential centres. They add to the availability of medical aid to the public. The relationship between a medical practitioner and a patient is that of trust and confidence, a very healthy relationship indeed.. But with the change of time something new has erupted in this relationship which has made a definite dent in doctor-patient relationship.. It is a contract for service. But when the service has been rendered satisfactorily upto the best of one's capability and knowledge, even then the patient drags the medical practitioner to the courts. Such practice has to be dealt with a heavy hand. Under the neo garb of awareness the patient should not file a frivolous complaint. In every case, the doctor cannot be indicted and made to pay compensation. In case the complaint is malafide, the same can be dismissed as such with costs. The case in hand is one of the examples of such complaints, more so it appears to be a case of sponsored litigation". These were

the comments of the Honourable presiding judge. It is important to note that the judge has asked that the public and the judiciary must take care to be cautious in their enthusiasm to use the Consumer Protection Act against doctors and dentists.

Doctor-Patient Contract

A contract is defined as an agreement between two or more persons, which creates an obligation to do or not do a particular thing. A contract may be express, e.g. a written document or implied, e.g. when a patient sits on the dental chair and opens his mouth when invited to do so.

In daily dental practice the contract is almost always an implied one.

When is it not a Contract?

If a doctor renders first aid in an emergency or when a government or judicial officer requests an examination of an offender, it is not a contract. Similarly, when a doctor examines a patient for insurance purposes, there is no implied contract.

Obligations under the Contract

Continue to Treat

While the doctor/dentist has the right to refuse treatment for any reason, he is bound by law to treat once he has agreed to examine the patient. He cannot **abandon** the patient after this, **except**:

1. If the patient has recovered from illness.
2. Patient refuses to pay the agreed fees.
3. Patient consults another doctor without the knowledge of the first doctor.
4. Patient refuses recommended treatment.
5. The patient is malingering (pretending to have a disease).

To Exercise Reasonable Care

Reasonable care is a much debated concept and will be analyzed through cases elsewhere. The doctor is bound to use clean instruments, order necessary investigations, perform procedures that he is competent to do, prescribe suitable medicines with clear instructions, explain complications etc.

He is bound to make appropriate references when:

1. The case is complicated and beyond his abilities, e.g. bleeding from tooth socket due to bleeding disorder.
2. Life threatening condition where he does not have necessary life saving equipment, e.g. Ludwig's Angina of dental origin.
3. Medico-legal cases and cases where foul play is suspected, e.g. assault, attempt to murder, poisoning etc.
4. When desired by patient/attendants.
5. When no one can give you an informed consent, e.g. patient has no relative or next of kin.

To Exercise Reasonable Skill

Reasonable skill is a relative attribute and it is difficult to draw a line between reasonable and unreasonable. For practical purposes it may be said to be "the average degree of skill possessed by his professional colleagues with the same background, education and experience."

He is not expected to show extraordinary skills. At the same time his skills must not be of a standard that is too low and unacceptable by the professional community.

Confidentiality and Privileged Information

A doctor has the moral and legal duty to respect privacy and not divulge details of his patient's disease or treatment to any one else. There are exceptions to this obligation. A

doctor may be bound to divulge secrets of patients if it is requested by the law enforcing authority or the judiciary. Details of a disease may also have to be divulged if the matter is of concern to public health or potential loss of an individuals life, e.g. methicillin resistant *Staphylococcus aureus* (MRSA) or plague or smallpox.

Reference and Second Opinion

A dentist must be reasonably skilled if he wishes to undertake a complicated procedure with attendant risks in the form of morbidity or mortality. Appropriate **references** to specialists or other dentists or physicians with specific competence in that area is a legally wise thing to do. This is a standard practice in India.

The concept of second opinion is however not a very popular *modus operandi*. It is quite popular in many western countries. When one is in doubt about the diagnosis or treatment he may refer his patient to a colleague for an opinion. It is not an acceptance of ignorance or incompetence but rather a reaffirmation of his opinion from another colleague. The doctor/dentist who is asked to provide a second opinion may concur or differ with the primary doctor. It is an unwritten moral principle that the second doctor refers the patient back to the primary doctor with his opinion and does not take up the case unless specifically asked to do so.

Chapter 5

Medical and Dental Negligence

What is Negligence?

It can be said to be a failure to take due care resulting in injury. It has been defined by Alderson as “the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do”

We therefore understand that for an act to be considered negligent, the following aspects must be present:

1. That the doctor owed a certain standard of care.
2. That the doctor did not maintain that standard.
3. That there was an injury resulting from the lack of care.
4. There should be a connection (proximity) between the negligent act and the resultant injury.

When is it not Negligence?

Normally, carelessness is not culpable or a ground for legal liability, as there is no wrongful intention **but** in medical negligence carelessness is taken seriously and the law has imposed a duty of carefulness on the doctor or health worker. But many other acts that patients commonly complain about don't fulfill the requirements mentioned earlier.

A review of consumer cases, show that some of the situations mentioned below, do not come under medical negligence, e.g. not providing an ambulance, due to non-availability is not negligence.

Not obtaining a consent form in an emergency is not negligence.

Patient's dissatisfaction with progress of treatment cannot be called negligence.

Similarly, not getting desired relief is not negligence.

Non-availability of beds in an ICU is not negligence.

Giving precedence of one patient over the other based on priority is not negligence.

Charging, what the patient thinks is exorbitant is not negligence.

These are some examples and do not constitute a comprehensive list.

Elements of Negligence

Legally the tort (civil wrong) of negligence can be established against a dental practitioner only if the following elements are present:

1. That the dentist has a duty to care for the patient. He does not owe a duty to care if the patient has not been accepted as a patient. This is sealed when the doctor-patient contract is established.
2. A violation of the above duty.
3. An injury to the patient.
4. A proximate relationship between the violation and the injury.

Duty of Care

Is there something called minimum standard of care?

The degree of carelessness for a particular profession depends on the risk that it poses to the person who is exposed to it. This question does not arise if there is intention involved in an act. Then it is not carelessness and there can be no question of degree. It therefore needs to be addressed as a different legal violation, e.g. intentional injection of a poisonous substance to cause death.

Professional standard of care is generally that standard of care or skill that is laid down by a body of professionals on behalf of the medical profession.

If skill and knowledge fall below this established standard it will be considered to be negligent. A Body of Professionals can establish this standard by publication in books, reports of scientific studies or by protocols established by them (e.g.) Textbooks, journals, or protocols of associations like Indian Medical Association, Indian Dental Association, American Heart Association, etc. Medical Science, met being an exact science, will have different professional opinions on the diagnosis or treatment of a disease. In these situations the adoption of an alternate method recognized by another body of professionals will be acceptable as a valid procedure and will not be considered as negligence.

In this context it is important to discuss the semantics of customary and acceptable.

A dentist cannot adopt a procedure merely because it is customary. Customary standard has been looked at critically because it does not provide incentive to adopt better practices. Because a particular procedure has been done for many years, does not make it an acceptable practice. An acceptable practice on the other hand is not only time tested but also scientifically sound. An acceptable practice is usually the product of evidence-based medicine or dentistry as opposed to customary practice, which is usually anecdotal. For instance Arsenic has been traditionally used to devitalize the pulp in endodontics. However current endodontic practice unequivocally disapproves the use of arsenic due to potential complications. It may therefore be said that, while the use of arsenic was customary, it is not an accepted practice today. A complication produced by arsenic may therefore be said to be negligence.

An American court held “The skill diligence, knowledge, means and methods are not those ordinarily or generally or customarily exercised or employed, but those that are reasonably exercised or applied, negligence cannot be excused on the ground that others practice the same kind of negligence”.

It may therefore be said that a “health worker is under a duty to use that degree of skill which is expected of a reasonable competent practitioner in the same class to which he belongs, acting in the same or similar circumstances”. The Supreme Court has defined this duty in the case of Indian Medical Association Vs V.P. Shanta as “In general a professional man owes to his client a duty in tort (civil wrong) as well as in contract to exercise reasonable care in giving advice or performing services”.

Importantly the court held that this standard should be outlined by the medical profession and it is not the duty of the “Lay Courts” to decide on what constitutes ‘standard’ care. Negligence, in these situations may be dependent on the locality, availability of facilities, specialization of the doctor, proximity to specialists and advanced technology.

However it is important to remember the dictum “no man is bound in law to be a good surgeon, but all men are bound *not to act* as a surgeon until he is good and capable as such”.

The above dictum indicates that a doctor or dentist should not venture to do a procedure unless he is trained and competent in performing it. Merely admitting that he had little experience and therefore the mistake is no legal remedy. It is not legally wrong to be ignorant but it is legally wrong to act in ignorance.

THE TEST OF NEGLIGENCE

Medical and dental negligence have been tested in the Indian Courts but have not been adopted as a benchmark.

The Supreme Court in L.B.Joshi Vs T.B. Godbole and another described the test of standard as “The medical practitioner should bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor the very lowest degree of care and competence, judged in the light of the particular circumstance of each case is what the law requires”.

The Bolam Test

This is a classical test widely used in the United Kingdom. In fact the Bolam test is an acceptable test used by the National Health Service of the U.K. when a situation of negligence presents itself. The test is based on the case of:

Bolam vs Friern Hospital Managing Committee (1957)
2 ALLER 118

A psychiatric patient was given electro convulsive therapy (ECT) without the use of a muscle relaxant and with all normal precautions. He however developed a fracture during convulsions.

A case of negligence was filed against the hospital. However the hospital was cleared of negligence on the ground that a group of professionals felt that it was standard procedure to give ECT without muscle relaxant due to the potential risk of respiratory failure with muscle relaxant. This case was therefore referred to as the Bolam Test to differentiate a negligent act from an alternate procedure (endorsed by another professional body), which is also accepted as a standard procedure.

Lord Denning in a subsequent use of the test in: **Roe vs Ministry of Health** while exonerating a hospital for negligence warned “we must not condemn as negligence that which is only a misadventure”.

Negligence – Carelessness vs Recklessness

While both words have almost the same meaning, there is a small difference. A careless person may not think of the eventuality while being careless. On the other hand the reckless person is fully cognizant of the injury that his act may cause, but still takes the risk of possible injury. The former is passive, whereas the latter is an active act. Both acts are however are not intentional and is therefore often used to describe negligence.

Standards of Care in Hospitals

Legal standards applicable to hospitals are somewhat similar to those required of doctors or other health workers. The hospitals are bound to maintain standards in two ways.

- The facilities of a hospital should be that of a reasonable hospital engaging in similar type of health care.
- The hospitals should maintain standards laid down by statutory provisions (if available). Currently only a few states have statutory provisions (e.g.) The Tamil Nadu Private Clinics establishment Act or The Karnataka Private Establishment Act.

In addition the hospitals may be answerable for the negligence of their doctors, nurses and other health workers through what is called vicarious liability. This will be dealt with in a later chapter.

CONTRIBUTORY NEGLIGENCE

In some situations negligence arises fully or in part due to the patient's (plaintiff) fault. As the patient, wholly or partly contributes to the negligent act, it is called contributory negligence.

The standard to be adopted to assess contributory negligence is somewhat similar to the standard adopted for the doctor. It may be said "Contributory negligence is when

a competent adult (patient) may be negligent by contribution when his conduct falls short of the degree of care that society expects a reasonable person to do or not to do for his own safety". This would obviously preclude children and mentally incapacitated adult.

Examples

1. When a patient refuses to take a prescribed medication resulting in postoperative infection.
2. A patient who removes inter-maxillary wiring on his own resulting in non-union.

Remedy for Negligence under the Indian Legal Systems

Negligence can be:

1. Tortious (Civil wrong)
2. Contractual (Breach of contract)
3. Criminal
4. Vicarious (Liability passed on to hospital)

Negligence can be remedied depending on what legal provision the complainant wishes to seek remedy.

The punishment under the law of Tort (Tortious liability) is un liquidated damages, i.e. whatever damages the judge wishes to award depending on injury, circumstances and people concerned.

If a written contract was made between doctors and patient, then the remedy would be as specified in the contract. The judge may order a specific performance to do or not do something he has agreed to in the contract.

If the complainant seeks to punish the doctor he may file a criminal case. The remedy under criminal law is always in the form of a punishment (Penal). It may involve imprisonment or fine or both. Rarely the court can order compensation or specific performance as well. Criminal law

sees negligence as a crime against the state and not just against the plaintiff.

Sometimes, a doctor may not have to answer for his negligence directly. The hospital employing him may have to answer to the allegation of negligence. This is called vicarious liability.

All the above liabilities will be discussed in detail in the next chapter.

Landmark Judgement and Illustrative Cases

Dr Laxman Joshi vs Dr Godbole AIR (1989) SC128

A 20 year old boy had fracture of the femur. The doctor performed a reduction without anaesthesia. It was alleged that the patient died of pain shock. The doctor contested that he had given morphine and that death was due to fat embolism. The High court held that the doctors contention was only a cloak for death caused due to shock. The Supreme court reiterated that the doctor had certain duties which he owed to the patient. It also said skill and care should be used in any procedure undertaken by a doctor. This skill need not be of the very highest and certainly should not be low. It should be adequate and should be appropriate for a particular circumstance.

RA Parmar vs GRMI 1993(2) CPR 496

It is a settled case that if the complainant is not benefited by the system, it is a misfortune. In any treatment it is never claimed by the medical profession that every person who receives the treatment must and should be benefited by the same because the benefits of a particular type of system or operation or medicine depends upon a number of factors....Merely because the patient was not relieved from pain, one cannot jump to the conclusion that the system is bad or that the doctor has not given proper treatment. If

everyone has to be benefited by a particular medicine or operation, then nobody will die by disease.

Hatcher vs Black (1954) Times 2 July

"An action for negligence against a doctor is for him unto a dagger. His professional reputation is as dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body. You must not, therefore find him negligent simply because something happens to go wrong, if for instance, one of the risks inherent in an operation actually takes away the benefits that were hoped for, or if on a matter of opinion he makes an error of judgement. You should find him guilty of negligence when he falls short of the standard of reasonably skilfull medical men."- Lord Denning.

Bolam vs Friern Hospital (1957) 2 AllER 118

Already described earlier. Ref: Bolam Test.

FAQs

Can a patient sue for negligence if no injury has been caused?

Causation of injury is an important element in negligence, both civil and criminal. However, there is one exemption. According to Section 336 of the IPC, an act endangering a person's life can be included as criminal negligence even if no injury is caused by the act, e.g. doing a surgical procedure under intravenous general anaesthesia without oxygen or monitoring facility.

Who will decide what constitutes minimum standard of care?

Standard of care is not quantifiable. However for the sake of establishing a minimum standard of care the law will set what may be called a 'pragmatic standard of care'. This is flexible taking into account the fact that medical treatment has many risks and undesirable outcomes. Therefore, the minimum

standard of care is the standard of an average practitioner of the class to which the doctor belongs or holds himself to belong. He needs to act in accordance with the practice accepted as proper by a responsible body of medical practitioners skilled in that particular art. Accepted practice is what is held by official publication or scientific opinion as good practice. If there are two schools of scientific thought, both are accepted. The court decides the issue based on inputs from the professionals.

If a patient develops complications on account of disregarding the dentist's advice, would it constitute negligence?

If it can be proved that the complication occurred partly or in full due to disregard or noncompliance of the doctor's advice, then it would be considered as contributory negligence (meaning that the patient contributed to the negligence). However this does not necessarily mean that the doctor will be completely absolved of his negligence. It will only lessen the responsibility of the doctor for the negligence.

Chapter 6

Negligence: Liability of Doctors

HOW ARE DOCTORS LIABLE FOR NEGLIGENCE?

Doctors are liable under four heads.

1. Tortious liability
2. Contractual liability
3. Criminal liability
4. Statutory liability

Tortious Liability (Civil Liability)

Tortious liability may be of two types:

1. Primary liability
2. Vicarious liability

Primary Tortious Liability

When a doctor or dentist is directly liable for an act of negligence in his clinic or hospital it is called primary liability. Most dental negligence would come under this category. Here the dentist owes a duty to his patient as well as to the public at large to practice his profession with reasonable care, diligence and skill. A breach of this duty resulting in injury can invite a suit for negligence. The remedy for breach of tortious liability is unliquidated damages as awarded by the Judge. It is usually in the form of compensation in cash.

Vicarious Liability

On the other hand dentists who are employed by a hospital or institution are often not primarily responsible for

negligence. They may be said to have vicarious liability through the hospital. The hospital has the liability for the negligence of an employee. This kind of liability is controversial and pinning the liability is sometimes a difficult proposition.

To understand with whom the liability of negligence lies, we shall review a few leading cases.

In Hillyer vs Governors of St. Bartholomew's Hospital, *during the course of examinations under anesthesia an injury was caused. The surgeons, anesthetists, nurses and hospital staff were all involved in the procedure. The court held that only the surgeons and anesthetists were responsible as they were performing on their own judgment and not on the directions of the hospital. On the other hand the nurses and hospital staff were acting on the instruction of the doctors and therefore not personally responsible.*

To fix a responsibility the test of master–servant relationships should be employed.

The case left unanswered, the question of whether the nurse was the servant of the operating surgeon in the operation theatre only during the operation or whether she was the servant of the hospital.

In Gold vs Essex County *however the nurses were considered the servants of the hospital, putting the primary liability for their action on the hospital. It also raised the question on the role of doctors as to whether they were servants of hospitals or independent operators. As a compromise it was held that doctors on permanent staff may be considered servants of the hospital, allowing the hospital to take vicarious liability for all its doctors and servants. The doctors/dentists admitting their own patients in a hospital, will however be liable personally for injury caused by them. The hospital in this situation may not have a vicarious liability.*

This was also upheld in **Roe. vs Ministry of Health** where Lord Denning reiterated the earlier stand of the hospital being permanently liable for the negligence of all kinds of doctors irrespective of whether they were servants.

The logic was that the hospitals should show care in selecting “good” doctors. If as a result of poor selection, a negligence was caused, it was the primary responsibility of the hospital.

This arrangement was good for patients, as they do not need to identify the person who was negligent in a chain of events in the hospital leading to the injury. The patient needs to only hold the hospital responsible for the negligence.

However in practice, for the sake of regularity, it may be said that all permanently or part time employed doctors are only vicariously liable. However, if the patient is admitted by a doctor/dentist in his personal capacity, then the doctor/dentist will be personally liable.

Contractual Liability

In a doctor-patient relationship an implied contract is established when a doctor accepts a patient for treatment. A breach of any aspect of this implied contract where the doctor is under duty to

1. Treat with care
2. Continue to treat and not terminate until patient is cured or the patient discontinues treatment.

May be considered a contractual liability. However, in most instances if there is no written contract their liability will essentially lie within the realm of tortious liability.

If there is a written contract, then any breach by the doctor will be a contractual liability and the remedy will be by specific performance as specified in the contract.

Written contracts with promise to cure, failing which a refund is assured is against the ethics of medical or dental

practice. It is the author's view that such contracts can be technically void, considering the ethical and legal issues involved.

Criminal Liability

This liability normally lies with an identifiable individual or groups of individuals. However, recent trends indicate that hospitals also may be held vicariously liable just as in civil liabilities.

Criminal liability is penal and involves punishment in the form of imprisonment or fine or both. Criminal negligence is considered to be a crime against society and not just the aggrieved party.

The important offences inviting criminal liability with regard to negligence are:

1. Sec 304 A (IPC)—Negligent homicide. A rash or negligent act resulting in death, e.g. death on the dental chair.
2. Sec 336 (IPC)—An act endangering the life of a person. (even if there is no injury), e.g. extracting a tooth for a patient with valvular heart disease without antibiotic prophylaxis against endocarditis. (even if he does not develop endocarditis)
3. Sec 337 (IPC)—A rash or negligent act causing simple injury, e.g. pain and swelling after extraction due to negligent extraction.
4. Sec 338 (IPC)—A rash or negligent act resulting in grievous injury, e.g. fracture of jaw during extraction due to excessive or improper force.

While these are the common sections a dentist may be liable under, there are other sections as well. Any offence against the human body (Sec 299-377) or offences against property (Sec 378-462) can be used against dentists or doctors, e.g. abetting suicide, causing miscarriage Sec 312-316 (Subject to exemption from the Medical Termination of Pregnancy Act 1971) etc.

Sections 78,80,81,87,88 are directly or indirectly relevant to the medical practitioner. Section 88 for instance is an act done in good faith not intended to cause death. It is a good defence in emergency care. Section 86 and 87 IPC is in respect to harm or death caused by an act not intended to cause harm or death and is done with consent. Section 499 deals with defamation. It can be used by doctors/ dentists to counter malicious charges by patients intending to spoil the good name of the doctor by frivolous or vexatious charges.

It is important to understand some terms in connection with criminal liability.

Cognizable offence: Can offence where a police officer can, based on his investigation arrest a person without a judicial warrant.

Non-cognizable: An offence, where an arrest can only be made by a judicial warrant.

Bailable: *The arresting officer can give a bail.* Bail is a matter of right and has to be given unless the officer apprehends that the accused may abscond or tamper with evidence.

Non-bailable: Bail can be secured only from a judge. Heinous and violent crimes fall in this category, e.g. If there is a significant risk that the offender may commit further crimes, abscond or tamper with evidence.

Compoundable: A crime in which a compromise between the suspected offender and the victim or his representatives can be worked out is said to be compoundable

Non-compoundable: If the crime is against society and is of a serious nature, no compromise can be made between the accused and the victim. These cases are said to be non-compoundable.

Sec 304 A is cognizable, bailable and non-compoundable. It can be punished with imprisonment of either description for a term of two years or fine or both.

Sec 337 and 338 are cognizable, bailable and compoundable. Sec 337 may attract an imprisonment upto 3 months and a fine upto Rs 250 or both. Sec 338 can involve imprisonment upto 2 years and a fine upto Rs1000 or both.

It is important for the dentist to be aware of these liabilities. It is also important for him to understand his rights. For example, bail is a matter of right in the above situations and it is to be given by the police officer effecting the arrest based on the surety given by a colleague. He can be given surety on his own reputation. The burden of reasons for refusing bail rests on the police officer and he will have to give convincing reasons for **not granting bail**.

Representations to Amend Criminal Procedures for Arresting Doctors

The Indian Medical Association at the central and state level have been attempting to obtain a change in the arrest procedures for doctors charged with criminal negligence particularly under Sec 304 A (causing death by a rash and negligent act) and other sections which are cognizable where a station house officer can arrest based on preliminary investigation. Two important government orders have come out of these appeals.

Government of Kerala, Home Department, GO No: 73231/ss.B4/92/Home, Dated 20/3/93

The case is to be investigated by a police officer in the rank of deputy Superintendent of Police. He will refer the case to a panel consisting of superintendent of police or Commissioner of Police, District Medical Officer or Principal of a Medical College.

If there is difference of opinion, it will be referred to an apex body consisting of the Director of Health Services (M&PF). Doctors can directly approach the apex body.

Government of Tamil Nadu, Health Department

A less successful appeal by the state branch of the Tamil Nadu IMA was referred to the Justice Marathamuthu Commission. The commission recommended the following: G.O. (MS) No.133,Health:

1. To follow existing procedure of allowing the police to register a case under section 304A, IPC and investigate.
2. To permit an officer of the rank deputy Superintendent to investigate thereafter.
3. The order advises that the arresting officer must as a matter of routine consult senior officers to examine legal justification.

Statutory Liability

A doctor or nursing home is liable if there is any infringement of statutes. They then become accountable to a statutory body. The liability depends on the kind of infringement and the provisions in the statute to deal with it. There are many statutes dealing with practice of doctors and dentists, as well as hospitals. For example, the Tamil Nadu Private Practitioners Act, The Karnataka Private Medical Establishments Bill 1998 (see Appendix).

Doctors and dentists may also be liable to other statutory bodies such as The Pollution Control Board.

FAQs

Who decides if a negligent act is a tort (civil wrong), criminal or contractual?

Negligence cases are normally civil in nature and may be taken up in a civil court or a consumer court. However if the patient

or any competent person reports the case to the police or magistrate under any relevant section of the IPC it may be taken up as a criminal case. The police can investigate a suspicious death or injury even if there is no complaint.

Who is responsible for negligence by house surgeons, residents and clinical assistants?

The responsibility of negligence by a trainee or employee normally has to be taken by the employer. This is called vicarious liability. This is a controversial issue and courts have ruled either way in many decided cases. An employee who has the liberty to take a decision on his own and is qualified to do so may sometimes be held directly responsible.

Can a dentist enter into a contract that he will refund money if the patient is not cured or satisfied?

Any contract between a doctor and patient that purports to guarantee treatment failing which refund is promised is considered to be ethically and legally wrong. As any contract that is made against public policy is invalid, these contracts may be considered void.

Can a police officer arrest without warrant?

A police officer can arrest without a warrant if it is a cognizable offence. If there is a death in the dental chair it can be cognizable offence (under sec.304A). The police can arrest on receipt of complaint. However it is a bailable offence and the offender can claim bail as a right. If the alleged offence is a non- bailable one then the officer can arrest only with warrant from the magistrate (which is issued only if it is a serious crime).

How does one get a bail?

Bail can be obtained as a matter of right if it is a bailable offence. All criminal negligence cases are bailable. The police officer may give bail on the basis of personal bond or security furnished by a person of good standing in the society. A police officer can refuse bail only if he perceives that it was a heinous crime or if he suspects with good reason that the alleged offender will jump bail or tamper with evidence.

Can a dentist ask to call for help if arrested? Who should he call for help?

Yes! He can ask to call for a friend or advocate. The dentist should call an office bearer or senior member of his local professional association, who will help him to get bail.

Do statutory laws pertaining to practice bind a dentist?

Yes! He is liable for punishment if he contravenes a statutory provision.

Chapter 7

Negligence: Common Grievances of Patients— Case Reports

Deficiency in Care

A doctor/dentist has a duty to care, once he has initiated treatment. If an injury occurs due to failure to take care, he may be held liable.

Ishwardas vs. VK Gupta 1 (1992) CPJ 118NC

Complainant had a denture made for himself and his wife. The dentures were ill-fitting and caused ulceration in the mouth. The dentist did not rectify the mistake. The dentist was held liable.

Flower vs. SWMR (1995) 2 BMJ 387

A lady fell in her garden and had a wound in her arm in addition to a fractures.

The doctor applied plaster without cleaning the wound. The plaster was too tight and she developed gangrene and required amputation. It was held that the doctor was liable.

Munro vs. Oxford United Hospital (1958) 1 BMJ 167

A seven year old girl lost four teeth while applying a gag for tonsillectomy. Expert witness said it must have happened due to lack of adequate care in application of the tonsil gag. The doctor was held liable for damages.

Failure to Attend on Patient

The doctor/dentist is free to refuse treatment on valid grounds but has to continue treatment, once he has accepted

the patient. However, ethically a doctor is bound to offer emergency help if he is available.

Yasmin Sultana vs. R.D.Patel 1994 (1) CPR 407

A pregnant woman reported to a doctor at 11.00 PM with perceived labour pain. The doctor felt that it was pre-mature pain and did not warrant immediate treatment. Moreover, it was not his consultation time. The commissioner dismissed the complaint of failure to attend on the grounds that it was for a consultation outside his timings and it was not an emergency. He was at liberty to not be available for consultation.

The doctor's duty to attend must be bound by medical necessity not as per the demand of patient.

Abandoning a Patient

Having accepted a patient, the doctor must 'continue to treat'. The contract to treat ends only on completion of treatment or if the patient decides to terminate or by reference to another doctor.

Mr. Sakil vs. Dr P Irani 1992 (2) CPR 515

A patient in a serious condition following anesthesia was shifted to another hospital for want of ICU. The anesthetist did not accompany the patient, resulting in anoxia and brain death. It was held that the anesthetist had abandoned the patient.

However, if the patient leaves on his own, there is no responsibility for the doctor/dentist.

Fletcher vs. Bench (1973) 4 BMJ 118 CA

A patient who had a tooth extraction went on a holiday elsewhere. He developed swelling and infection while on

holiday and saw another dentist. The second dentist took an X-ray, which showed remnants of rods and he tried to remove the same, resulting in complications.

The first dentist was not held liable for abandonment, as the patient did not go back to him.

Other Illustrations

If a patient develops a cardiac arrest during a dental procedure, the dentist must remain with the patient and initiate resuscitation even while someone goes for help. If the dentist leaves the patient to look for help, it will be deemed abandonment.

Inadequate Instructions

Another common complaint is the failure to give advice clearly, resulting in complications. Dentists must clearly give instructions regarding the prescription, diet and post-operative care.

Illustration

Failure of dentist to advise a crown for root canal filled tooth with significant loss of tooth substance can result in fracture of tooth. The dentist will be held liable.

Md. Aslam vs. Ideal N H 1994(1) CPR 619

A patient had an abdominal surgery. She had a large quantity of food the next day against the advice of doctors. The surgical site opened up and she died. The doctor was not held liable, as the patient did not follow the advice given.

If patient has been negligent in following an advice, it shall be contributory negligence.

If advice given is wrong, then the doctor/hospital will be held responsible.

Fees

The doctor /dentist has the right to collect his fees from the patient for services rendered. Although ethics require that the fee be reasonable, the dentist is at liberty to charge what he thinks is appropriate.

As per requirement of the Income Tax department receipts are to be issued for all charges above Rs 25/ and entries are to be made of it in the prescribed daily books of account. A complete bill with break ups need to be given to the patient, if demanded. However, the patient cannot question the cost of professional services.

Motibai Dalvi vs. MI Govilkar II (1991) CPJ 684

The hospital made charges for telephone calls (which were not made) and cotton guaze, which was not used. The hospital was held liable to return the money.

RM Joshi vs. VP Tahiramani III (1993) CPJ 1265

The patient was charged for bed when the hospital had no beds. The clinic was held liable.

A Bhatnagar vs. Dr Patnaik III (1997) CPJ 368

Patient complained of excessive fee. The case was dismissed as fees did not constitute a consumer dispute or negligence.

BS Hegde vs. Dr S Bhattacharaya III (1993) CPJ 388NC

Patient was charged Rs.40,000 for surgery. The National Council felt the fee was exorbitant. However, NC ruled that the acceptance of high fees cannot be deemed to be deficiency in service.

BM Raja vs. Ar A Gambhir 1999 (2) CCC 48

A patient complained that the dentist charged Rs. 150 for an extraction whereas other dentists charged less. It was

held that in professional service, the fees charged cannot be questioned and there is no fixed charge. The charges may depend on skill, drugs used and experience of dentist.

Other similar observations include:

SK Jain vs. Dr A Mathur 1999 (1) CCC 106.

Dr. Kapoor vs. Phooldev Prashad III (1996) CPJ 477.

Foreign Body

Foreign bodies left behind in the body is a common cause for filing suits. In dentistry, this is quite common. Foreign bodies such as amalgam in tooth sockets, broken root canal instruments, bur tips in bone etc can invite accusations of negligence. Unlike foreign bodies in abdomen, e.g. Like scissors or pads, the foreign bodies in dentistry are not of great significance.

Some endodontic specialists advice retaining the broken reamers if it cannot be retrieved by conventional techniques. Implanted amalgam can remain for years without causing problems.

Foreign bodies in other parts of the body are however viewed seriously and indicate negligence per se or Res ipsa Loquitur (the facts speak for itself).

Accidental ingestion of crowns, dental instruments, teeth etc. can also be construed as negligence.

K.K.Radha vs. Dr. G.V.Sekhar III (1994) CPJ 376

Drill bits and wire pieces were embedded in tibia after first operation for fracture reduction. The doctor and hospital were held liable.

Mrs. Rohini Kabodia vs. Dr. R.T.Kulkarni III (1996)

The patient had pain and fever following a caesarian. Sonography and exploration revealed the presence of a

metallic suction tip. The doctor was held liable and was asked to pay Rs. 2 lacs.

Cooper vs. Miron (1927) 2 Lancet 35

In the process of tooth extraction, one tooth was aspirated. The patient developed pneumonia and died. The doctor was held liable for negligence.

Certificate

False or incorrect certificates cannot only invite cases of negligence but also constitutes serious misconduct and criminal liabilities.

Evert vs. Griffittles (1920) 3KB 163

A doctor certified a boy insane and locked him in an asylum but the boy was later found to be sane. The doctor was held liable.

Routtey vs. Worthing HA CA 14 July 1983

Similar case as above.

Confidentiality

The information given to a doctor is privileged information and it can be breached only in exceptional situations.

The doctor and dentist is legally and ethically bound by confidentiality. It is dealt with elsewhere in detail.

Information about patients, released in the interest of public safety is not breach of confidence. In fact, in some situations failure to inform is construed as negligence by the doctor/dentist.

Dr T vs. Appollo Hospital III (1998) CPJ 12 SC

The complainant, a doctor was found to be HIV positive during pre transfusion screening. The hospital on knowing

his intention to get married, informed his fiancée. This caused the marriage to not take place. The complainant's stand that his right to privacy was a fundamental right was not accepted in view of it clashing with Sec 269 and Sec 270 of IPC (negligent and malignant act likely to spread infection or disease, dangerous to life).

Failure to inform the fiancée would have amounted to abetment of crime and therefore the court ruled in favour of the hospital.

W vs. Egdell 1 A IIER 1089

A psychiatric patient with a violent disposition was seen by a doctor, who disclosed the matter to the home office. The patient filed a suit for breach of confidentiality. The court held that the doctor acted in public interest and was not liable.

Doe vs. High –Tech Inst (Colorado Court of Appeal July 9, 1998)

A student was made to take a HIV test without his knowledge by making him sign a consent form for Rubella screening.

The Court held that there was no public policy reason to test the plaintiff. HIV testing can only be performed by an authorized laboratory and only with the permission of the person concerned.

Injections and Allergies

Dental surgeons use injections as a routine. One of the disadvantages of injections is that it cannot be retrieved, once given. The obvious advantage is that it is fast acting and often needs to be given in emergencies. The injections may be intramuscular, intravenous, subcutaneous, injections into tissue planes etc.

Injections are unfortunately the cause for many negligence suits. Some of the unwanted complications resulting from injections are:

1. Anaphylaxis.
2. Local pain and swelling.
3. Injection of wrong substances.
4. Inability to effect venipuncture.
5. Infection and abscesses at site of injection.
6. Broken needles.
7. Wrong site of injection
8. Wrong route of injection.
9. Wrong dose.

Some illustrative cases are given below:

Spring Meadows Hospital vs. H Ahluwallia 1 (1998) CPJ 1SC

The patient was administered chloroquine IV instead of chloromycetene as the nurse miss read the doctors orders. The child died due to brain damage. The hospital was held vicariously liable to pay Rs 17.5 Lakhs.

Chin Keow vs. Govt of Malaysia (1967) 1 WLR 813

The patient was given penicillin without test dose and developed anaphylaxis and died. The hospital was held liable.

Dr Kushaldas vs. State AIR (1960) MP 50

An injection of penicillin without test dose caused death. The doctor held liable.

Kharatilal vs. Kewal Krishnan 1 (1998) CPJ 181

A patient with abdominal pain was given four drugs intra-arterially instead intravenously causing gangrene and requiring amputation. The doctor was held liable.

However, if complications develop despite best care and the cause cannot be explained, then the doctor/dentist is given benefit of doubt.

Y Ramamurthy vs. Dr Nagarajan. I (1997) CPJ525

Patient developed pain and swelling at injection site despite the doctor using aseptic technique and disposable needle. The case was dismissed as there was no contrary evidence.

In case of needle breakage the patient must be informed. There will be no negligence if that is done.

Gerber vs. Pine (1935) SJ13

The needle broke while the injection was being given. The doctor did not reveal it to the patient. Later, the needle became infected and had to be surgically removed. The court did not hold the doctor negligent for the broken needle but attributed negligence in not informing the patient.

Prescription

It is one of the most common acts of a doctor. If prescriptions are not clear and if they do not have proper instructions, the doctor is deemed to have been negligent. Moreover prescriptions are documentary evidence and therefore easy to prove. doctors/dentists should be careful when prescribing drugs.

Prendergast vs. Sam and Lee Ltd (1984)

The Times 14 Mar

A patient was prescribed amoxyl (amoxicilin) for an upper respiratory tract infection and the pharmacist gave him daonil (a hypoglycaemic). The patient developed hypoglycaemia, coma and brain damage. The doctor and pharmacist were held liable.

Emergency

Emergency is not readily defined. It is a relative concept. A dental emergency such as reimplantation of a tooth may not be perceived as an emergency by a trauma team dealing with a femur fracture. Yet the loss of the tooth may have far reaching consequence on the individual.

Another aspect of emergency is medical emergencies that may occur in the dental office. A doctor/dentist is bound by law and ethics to deal with emergencies. Failure to deal with emergencies can attract clauses of negligence against doctors even if there is no contract between the doctor and patient. The good samaritan law in the USA was legislated to protect doctors and lay persons who go to the aid of critical patients outside the sphere of the hospital. According to this law any procedures done in good faith cannot invite malpractice suits.

Baby K.(SC,1994 WL 31441 WSL 3 3009)

The supreme court noted that the emergency medical treatment and active labour act (EMTLA) was passed with the intention that all patients attending a medical centre must be given first aid or stabilizing treatment irrespective of whether the patient is identified and has the means of payment or not. The patient may be shifted only at his own insistence or if the doctor feels that it is imperative to move him to a better equipped centre.

In emergencies

1. Consent is not required.
2. Drug reactions are not considered negligent.
3. Any act done in good faith is exempt from clauses of negligence.

Any doctor can take-up an emergency. A patient cannot be refused treatment on the ground that it is a medicolegal

case and therefore to be seen in a government or approved hospital.

P Kataria vs. Union of India AIR (1989)SC2039

A patient injured in a road traffic accident was taken to a hospital where he was refused treatment on the ground that it was a medicolegal case and he would need to seek treatment elsewhere. The patient died on the way to the next hospital. The first hospital was charged with negligence on account of failure to treat. The supreme court in a landmark judgment held that all doctors need to extend treatment to the injured without waiting for any formalities. The doctor may be guilty of negligent death if he fails to provide emergency care.

Right to Information

All patients have a right to information about the procedure and possible outcomes. Failure to explain may be construed as a negligent act. It may however not be necessary in an emergency. If a procedure has significant risk of death, then the matter can be communicated to a near relative.

The patient does not have a right to access his hospital records. Failure of a doctor/hospital not to furnish records is not negligence.

Lee vs. SW Thames RHA (1985) 2 AllEr 385

The court ruled that a doctor has a duty to answer patient's questions.

Poona Medicals vs. Maruti Rao 1986-96 Consumer 2656 NC

A patient wanted the medical records pertaining to her surgery. It was not the hospital's policy to submit records. It was held that there was no negligence, as there was no convention or rule in India to hand over the records.

P Krishnaswamy vs. Appolo Hospitals. I (1999) CPJ 119
It was held that the hospital was not negligent in not handing over the records. A discharge summary was good enough.

The court may however requisition records to prove negligence.

Walker vs. Eli Lilly (1986) 136 NLJ 608

It was held that doctors and hospitals must make available the records and respond speedily in the interest of investigation except, if there were sufficient reasons of confidentiality.

Interesting Dental Cases

Parmley vs. Parmley (1945) 4DLR81.

A patient requested that two of his teeth be removed. The dentist found all the upper teeth in a stage of advanced periodontitis and mobility. He extracted all the teeth. The dentist was held liable.

Garner vs. Morrell (1953) Times 31 Oct. CA.

While extracting a tooth the gauze slipped into the throat and caused asphyxiation resulting in death. The dentist was held liable for the death of the patient.

Lock vs. Scantlebury (1963) Times 25 July

A dentist did an extraction. Subsequently, the patient complained of pain and difficulty in eating and speaking. The dentist prescribed drugs. Later, it was found that he had dislocation of the jaw. The court held that dislocation itself was not negligence, but his failure to recognize the TMJ dislocation was negligence.

Ishwardas vs. VK Gupta I (1992) CPJ 118 NC.

Ill fitting dentures which were due to poor technique resulting in ulceration and pain. The dentist was held liable.

Chapter 8

Informed Consent

The concept of informed consent is based on the premise that each individual has a right to make decisions concerning his health, disease and treatment. To enable him to take a decision he must be informed about the procedure to be undertaken and its relative benefits and potential complications. In a doctor-patient relationship it is the **duty** of a doctor to explain the procedure and complications and it is the **right** of the patient to accept or reject the treatment.

Risk may be defined as 'exposure to a **chance** of injury.' Chance relates to an uncertain possibility of some event, which is undesirable for the patient (injury).

Consent need not necessarily be spelt out. Sometimes, consent is implied.

If a patient attends a dental clinic and sits on the dental chair at the dentist's invitation, it is an implied consent to be examined. This act will not need a written informed consent. In fact it will be practically impossible to obtain consent for every small act.

When a doctor/dentist proposes to do a diagnostic or treatment procedure and if the procedure has material risks, then it must be explained to the patient.

What risks are material?

Material risks are determined by the 'the prudent patient test' which determines what a reasonable patient in the position of a plaintiff (complainant) would attach significance to, in coming to a decision on the treatment advice given. The dentist must foresee what side effect or complication a patient may consider to be significant.

For example, a patient may not place significance on some mild pain and swelling after an extraction. It is therefore not necessary to obtain informed consent for the same. However, a patient may be upset over a prolonged or permanent paraesthesia after the surgical removal of wisdom teeth. Therefore, when doing a difficult surgical extraction of mandibular molar it may be wise to obtain consent after explaining the possibility of transient or permanent paraesthesia. The ability to discern, that which the patient might perceive, as worth knowing about before a procedure is called the '*prudent patient test*'.

Where did the concept of informed consent come from?

One can trace the origins of the law of informed consent to the 'intentional tort of battery'. An individual has a right to be **not** touched by another person in a way that can cause injury. If he is to be so touched it should be with permission to do so. This may be adopted to a patient doctor relationship. When a doctor does a procedure without intimating his patient about potential complications and if the patient suffers from such a complication it may be construed as 'Battery' (assault). Similarly if a doctor performs a procedure different from that for which consent was obtained it may constitute battery. In both the above cases unconsented touching has occurred and therefore it may be construed as battery.

However popular judicial opinion felt that too much of a burden was being placed on the doctor by bringing non consented touching as battery and therefore failure to obtain consent has been brought into the realm of negligence. In order to recover damages for such an eventuality the patient must establish the four elements of negligence:

1. The doctor/dentist had a duty to inform the patient of possible complications (disclosure).

2. The doctor/dentist did not fulfill the above duty.
3. The patient would have refused the procedure if disclosure of potential complication had taken place.
4. The procedure was the cause of injury (proximate cause)
The complainant suffered a compensable injury.

Schloendorff vs. Soc of Ny Hospital 103 NE (92) 114

It was held that every human being of adult years and sound mind has a right to determine what should be done to his body and a surgeon who performs an operation without a consent commits an assault for which he is liable.

Exceptions to the Requirement of Informed Consent

A doctor need not inform a patient if he thinks that informed consent can upset the patient or negatively affect outcome. For example, a patient needing a life saving procedure, where there is a high risk of morbidity or a mortality. Similarly, a consent cannot be obtained from a minor, lunatic, inebriated person or a person in coma. In the above situations consent can be obtained from a parent, guardian or close relative.

Other situations not requiring informed consent are:

Medical emergencies.

A person with contagious or notifiable disease.

Immigration and quarantine requirements.

Patients dealing with public food and drink manufacture or distribution, e.g. dairy workers

Psychiatric examination ordered by the court.

Examination of criminal accused at the request of police or the courts S.53 (1) Cr.PC.

Freeman vs. Home Office (1984) QB524

A prisoner behaved violently and disruptively. The medical officer prescribed a tablet which the prisoner refused. He

was then given injection. The prisoner alleged that he was medicated against his wish. It was observed that a prisoner in custody can be assessed and treated by the prison doctor in an emergency.

MK Varghese vs. San Joe Hospital 1992(2) CPR 495
A patient admitted for her second delivery (first was by Caesarian 14 months earlier) was treated by a doctor who found that the Uterus was unhealthy and ready to rupture. He did a hysterectomy after the delivery in the best interest of patient without consent. The doctor was not held liable as he had done it in an emergency.

Important Elements of Informed Consent

Informed consent is an often-misunderstood concept. Many doctors think that mere acceptance by the patient verbally or in writing to the general possibility of complications and absolving the doctor for any or all complications is an adequate informed consent. It is not sufficient. The material risk inherent in a particular procedure should be clearly and unambiguously described to the patient with alternate options available.

The consent form should be in a language understandable by the patient. It should be remembered that the mere thumb impression on a consent, which the patient cannot read, due to illiteracy or lack of knowledge of the language is invalid.

State of Haryana vs. Smt Santra. I (2000) CPJ 53 SC.
The patient had put a thumb impression on a consent form stating that in the case of failure of family planning operation (tubectomy), the doctor would not be responsible. The consent form was held invalid.

If the patient cannot read, the doctor in the presence of witnesses should explain the details, in simple understandable language.

Specific complications must be explained for a particular procedure. For example, a patient who is to undergo a surgical removal of an impacted tooth must be told of the possibilities of nerve damage, injury to adjacent tooth, swelling and discomfort and even the possibility of mandibular fracture (if anticipated).

Where Informed Consent is to be Obtained

1. In any diagnostic procedure, particularly invasive procedures. Risk from large doses of radiation may also need to be told.
2. Laboratory investigations, particularly in sensitive conditions such as HIV, where public perception can stigmatize individuals found to be positive.
3. Prescription or administration of drugs with potential side effects.
4. Performance of any medical or surgical procedure with attendant morbidity or mortality.
5. Procedures that can cause sterility or impotence require the consent of husband and wife.

Rina Prakash vs. Dechi Ganapathy. 111 (1994) CPJ 358. Consent from spouse was not taken before sterilization. Doctor was held liable.

Oral Consent

Consent need not necessarily be in writing. Oral consent in front of witnesses and implied consent, which is determined by the behaviour of the patient is acceptable consent in certain situations. This is particularly true of simple procedures in dentistry.

M Arunachel Vadivel vs. Dr N Gopinath 11 (1992) CPJ 764

Complainants mother had a thyroid swelling. She consulted a surgeon, who after investigation found her in need of surgery. She consented to the same and was taken-up for surgery. She died of unexpected complications. Oral consent was accepted as consent for surgery as she was awake and conscious until the time of surgery.

Informed Consent in Research

Any individual volunteering in a research programme has the right to know the aim of the research, the risks that he may be exposed to, the remedy for the risks and whether costs would be borne by the researchers and whether he can withdraw from the experiment at any stage.

Many ethical and legal dilemmas arise out of research. They have been addressed from time to time by monitoring bodies (both governmental and non-governmental), to protect the interests of the participating persons. Most research activities are governed by institutional review boards and ethical committees.

Penal Provisions in India

Medical practitioners who violate the law of Informed consent are liable to be removed from the rolls of the Medical Council of India/Dental Council of India. The IPC makes the offence punishable with a fine or imprisonment, depending on the case.*

* A sample informed consent form maybe found in the Appendix.

FAQs

Is it necessary to take informed consent from every patient for every procedure?

It may be practically impossible to take an informed consent for every dental procedure. However, if there is a procedure, which may have complications or undesirable consequences, which a prudent patient not expected to anticipate, it is necessary to get an informed consent. E.g. swelling after a surgical extraction is an anticipated complication for which an informed consent is not necessary. However, a patient with a deep impaction in an abnormally thin mandible will need to be informed of a possible fracture and the procedures, which may have to be done in such situation.

Will not detailed information scare the patient from accepting treatment?

There is a reasonable possibility of scaring a patient with potential consequences. That is the price one pays for defensive practice. Good communication skills and choice of words can, to an extent, mitigate a frightening narration.

Can a patient sue even though an informed consent was taken prior to treatment?

An informed consent is a complex document. It is unclear how much information about risks needs to be revealed. Many hospitals and medical professionals modify their consent forms depending on new issues that come up from time to time. The important thing is to ensure that the patient understands the specific risks and consequences that is attendant to a procedure or test. A general explanation about risks and a statement absolving the medical professional is inadequate and will not constitute a valid informed consent. Even an exhaustive consent from a patient who is not in a state of mind to make a sensible decision may be invalid. Patients may often refer to a signature on an informed consent as an act done in desperation or agitation. Fiduciary relationship between doctors and patients may also render an otherwise perfect informed consent as invalid. So the answer is that an informed consent is not an absolute safety net.

Is it necessary to take consent before testing a patient for HIV?

Yes! Routine screening for HIV status (which is practiced extensively in India) is ethically and legally wrong. Pre-testing counseling and post testing counseling are prescribed protocols for HIV testing.

Chapter 9

Legal Procedure and Evidentiary Requirements

(With special reference to medical/dental negligence legal procedure (procedural law) relevant to medical/dental negligence)

It is important for the doctor/dentist to know the legal procedure involved in medical negligence. The legal procedure is slightly different for civil negligence, criminal negligence and negligence under the Consumer Protection Act.

To understand legal procedures one must be familiar with some of the procedural laws. They are:

1. Civil Procedure Code
2. Criminal Procedure Code
3. The Indian Evidence Act
4. The Limitation Act
5. The Court Fees Act
6. Procedure under CPA.

The Evidence Act

It is a very important procedural law.

There are three concepts in evidentiary law.

1. Facts
2. Facts in issue
3. Relevant facts.

The facts are the material evidence.

The 'facts in issue' are those that have to be explicitly proved. The facts in issue are proved by bringing into evidence the relevant facts. Section 6 to section 55, deal with these relevant facts.

There are also other rules in evidence law.

For example, The treatment card is material evidence.

The entries made in the card are facts in issue.

The evidence to prove that the entries made were by a particular dentist on the said date are relevant facts.

Who needs to bring in evidence?

The person who has to legally bring in evidence to prove or disprove a fact is said to have the “burden of proof”. When one has the burden of proof he has:

1. The burden of establishing a case
2. The burden of introducing evidence.

The general rule (with some exception) is that the onus of proving any particular fact lies with the party who alleges it and not with the party who denies it. In other words the onus of proof lies with the complainant and not with the defendant.

Negligence can be proved by

1. Direct evidence
2. Circumstantial evidence
3. Res ipsa loquitor (The matter speaks for itself)

Another aspect of evidentiary law is **standard of proof**.

The standard of proof in civil cases can be based on probability and circumstantial evidence. However, in a criminal case, the standard of proof is more stringent and should be beyond reasonable doubt as sanction (punishment) in criminal law is more severe and penal in nature.

The Limitation Act (1963)

It is the statute dealing with the time limit for instituting various suits, appeals, bail application and other legal actions.

Cause of Action

This refers to the incident, which has necessitated a legal process. Limitation period begins as soon as the cause of action takes place. The period of time varies according to the suit and it is given in the schedule of limitations.

Appeals/Application for leave of appeals

For appeals the day of judgment marks the beginning of limitation period after giving time for obtaining the copy of decree (judgment order). This will not include 'writs' as the limitation Act does not apply to them.

If a suit or appeal is made after the statutory limitation period, the court may reject the petition on grounds of being barred by limitation. The court may however accept a petition even if it is barred by limitation, if it is satisfied that the delay was unavoidable. However, in criminal cases the Act does not provide a period of limitation. Criminal proceedings can be instituted at any time after the offence has been committed. However, as per the guidelines given in Section 468 of CrPC, the limitation periods run thus:

1. Six months for offences punishable with fine only.
2. One year for offences punishable with imprisonment upto one year.
3. Three years for offences punishable with imprisonment up to 3 years (not less than 1 year).

If the limitation period ends on a day when the court is closed, then the next working day is included as the limitation period.

It may therefore be said that a suit should be filed as soon as the cause of action occurs.

Court Fees Act (varies from state-to-state)

Any party who wishes to approach a court with litigation has to pay a court fees with some exceptions like the

consumer court. Each state may have a different court fee structure. In a suit for money, the fee is usually computed based on the amount claimed by the plaintiff. Court fees are paid in the form of stamps which may be adhesive or impressed or both.

Procedure under Code of Civil Procedures (1908)

Most cases of medical negligence come under the Code of Civil Procedure. The court that is approached must have the jurisdiction to hear the case. The jurisdiction may be geographic/territorial or pecuniary (the money involved) Sec 15 to 20 of CPC regulates the forum of institution of suits. If the plaintiff (complainant) and the defendant live in different court jurisdiction, it is the option of the plaintiff to decide where to institute a suit.

If a court has a pecuniary jurisdiction of only Rs. 1 lakh and if the suit is for Rs. 2 lakhs, then the suit will have to be filed in a higher court.

A suit has 4 essential elements.

- a. Opposing parties.
- b. Subject matter
- c. Cause of action
- d. Remedy or relief.

The procedure of a suit is as follows:

Institution of a Suit (Plaint)

This consists of presentation of a complaint, which is called the plaint. This can be done by the plaintiff (complainant) or by his advocate. The plaint has to be made to the appointed officer of the court.

The plaint must include the complainants version of the cause of action (the incident).

The defendant replies to the plaint defending every material fact alleged by the plaintiff and adding any new

fact in his favour. All the allegation in the plaint must be defended point by point. If this is not done, it may constitute acceptance of an allegation. The defendants reply is called the *written statement*.

The plaint and the written statement together are called the *pleadings*. It is important that (as per order 6, Rule 2, CPC) the pleadings should state only the material facts and not the law. The introduction of evidence will come only at a later stage and it should not be mentioned in the pleadings.

Requirements of a Plaint

The plaint should have the following points:

1. The name of the court in which the suit is brought.
2. The details of the place where the plaintiff and defendant normally reside.
3. The cause of action and the material facts.
4. The fact showing the court has jurisdiction-territorial and pecuniary.
5. Value of the suit for court fee purposes.
6. The relief claimed by the plaintiff.
7. If the plaintiff has legal disability – minor etc, it should be stated.
8. Amount of compensation sought.
9. If the suit is delayed, then the reason and grounds for exemption from the law of limitation should be mentioned.

The procedure for admitting a complaint may be found in order 7, rule 9, CPC.

The plaint should be filed along with a list of documents to be brought as evidence.

Court fees for service of summons to defendant should be paid as per stipulations.

Issue and Service of Summons

When a suit is filed against a person the defendant will have to be informed about it and that he has to appear in court to defend the accusations. This intimation is called the *summons*. This is prepared by the court and signed by the judge. It will indicate the time and date. The defendant or his lawyer has to appear before the court. The summons may be served directly to the defendant or defendants or an adult member of the household who in turn has to acknowledge the receipt. If the defendant cannot be traced it may be pasted in a conspicuous place or published in a reputed newspaper.

Written Statement (of the defendant)

The defendant has to make a point by point rebuttal of the allegations of the plaintiff. All the requirements of the plaint apply to the written statement also. The defendant has to produce substantiating documents as well. The refutation must be pointed and not of a general or evasive nature. Failure to refute any allegation may be construed as acceptance of the allegation.

Framing of Issues

The court will on the basis of the plaint and written statement, frame the issues. After the issues have been framed, the trial will begin.

The Trial

The plaintiff and the defendant can apply to the court to issue summons to witnesses who he feels may contribute to his cause. As per order 16 of CPC the parties have to submit to the court a list of witnesses not later than 15 days after the issues are framed. No surprise witnesses can be sprung on the other party as is commonly thought.

Examination and cross-examination of witnesses can be performed.

The Arguments of Both Parties are Heard

The court gives the final decision in the form of a judgment. Effect is given to the judgment by the enforcement of a decree and orders by the process of the court, so as to enable the decree holder (the party in whose favour the judgment was given) to reap his benefits.

On enforcement of the decree, the amount due, can be claimed:

1. By the decree holder (winner of the case).
2. His authorized representative.
3. The transferee of the decree if it has been transferred to another person. (The person who has been awarded the compensation can transfer the 'award' to a third person to collect. He is the 'transferee').

If the judgment debtor (the party who has to pay) does not pay the amount stated in the decree, the court can resort to other means including attachment of property and auctioning of the same.

The patient who has alleged negligence has to follow the above procedure to claim compensation under the law of Torts (civil law) and under law of contracts.

Procedure under the Code of Criminal Procedure

When a case of negligence is sought to be tried under criminal law, it shall be governed by the Criminal Procedure Code. For the medical community this has become a sore point on account of medical practitioners having to undergo the ignominy of getting arrested by a police officer who may not be able to make a decision as to whether the alleged act was indeed negligence. Doctors and dentists have made numerous representations through their associations to deal with negligence (under criminal law) with caution, as it may

be unjust to allow a decision on negligence to be taken by a police officer, who may not understand the complexities of the medical problem.

However, as the law stands today, doctors or dentists are liable as per the existing code of criminal procedure.

When an offence (criminal negligence) is brought to the notice of a police officer of the police station in whose territory the offence was committed, the competent police officer (Inspector of Police) in charge will need to investigate it himself or depute another to do it.

The police are entitled to search, question witnesses, gather material evidence or take other necessary steps for the purpose of investigation. All the information relating to the commission of a cognizable offence (where arrest can be made) will be reduced to writing and will be read to the informant and will be signed by the latter. This is the FIR (first information report). A copy is given to the informant. If the offence is cognizable, the police officer can arrest the accused doctor/dentist. Many medical negligence clauses come under cognizable offences, e.g. sec 304A etc. However, most of them are bailable. Bail is a matter of right and the police officer is bound to give it except if it is a heinous crime or if there is a perception that the doctor may abscond. *There is no use in asking for an anticipatory bail or approaching the magistrate, as the arrest and bail are the duties of the police officer in a cognizable offence. It is better to co-operate.*

After the investigation is complete a report is sent to the Magistrate asking him to take cognizance of the offence.

The case is then committed for trial. The magistrate may then issue a summons or a warrant depending on the nature of the case.

A complainant can approach the Superintendent of Police or the Magistrate if the Police Station refuses to take his complaint.

In non-bailable offences, the accused has to apply to the court for bail. The court may or may not grant it, after taking into account the merits of the case.

Chapter 10

The Consumer Protection Act and its Procedures

On April 9, 1985, the General Assembly of the United Nations, by Consumer Protection Resolution No.39/248, adopted the guidelines to provide a framework for Governments, particularly those of developing countries, to use in elaborating and strengthening consumer policies and legislation. In 1986 India adopted the Consumer Act to enhance the rights of the consumer. The law finds some common ground with the law of torts, which is an English legacy.

The Consumer Protection Act 1986 came into force on 15th April, 1987 as a three-tier quasi-judicial machinery. The Act has been amended by the CP (Amendment Act) 1993 with effect from 18th June, 1993. Consumer Sec 2(d) of the CP Act says that a consumer is one who

- a. Buys goods for a consideration (payment) which has been paid for partly or in whole.
- b. One who employs the service of another for a consideration, which has been paid for partly or wholly.

It also includes a user or beneficiary of goods or services other than the person who actually buys the goods or avails services where such use is made with the permission and approval of the purchaser/buyer.

The Consumer Protection Act was essentially envisaged to cover business and trade and to protect the interest of the buyer of goods and user of services who pay for the same.

The Supreme Court has on various occasions clearly defined the terms business, trade, profession, etc., The term

profession and service are of particular interest to the medical profession.

The reason being that in a landmark judgment “Professional Service” was brought into the ambit of the CP Act.

The dictionary meaning of profession is, among other things, vocation, calling especially one that involves some branch of learning or science (divinity, law and medicine). Profession is distinguished from an occupation, which is substantially the production or sale, or arrangements for the production, or sale of commodities profession involves personal intelligence and skill and a professional depends on their attributes.

In the CP Act service as per Sec 2(c) is defined as “Service means service of any description which is made available to potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, processing supply of electrical or other energy, board or lodging or bath, house construction, entertainment, but does not include the rendering of any service free of charge or under a contract of personal service”.

In view of the above meaning of “Professional Service” there was some ambiguity on whether medical professional services could be considered as service. The medical profession, on account of its unique nature of service had pleaded to be left out of the Consumer Protection Act and that its services should not be considered for deficiency of service. Sec 2(g) which defines deficiency as “deficiency means any fault, imperfection or short coming in quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any services”.

In the Supreme Court judgment of IMA vs. V.P.Shanta and others, the court clearly states that professional services rendered by professionals such as doctors and dentists clearly fall into the definition of Sec 2(o) of the CP Act and therefore doctors and dentists cannot dispute the applicability of 'deficiency of service' to the services they render.

One of the reasons for bringing medical negligence into the ambit of the CP Act is because the Indian Medical Council Act 1916 and the Indian Dentists Act 1948 had no provision:

1. To entertain any complaint from a patient.
2. To take action against medical/dental doctors in cases of negligence.
3. To award compensation.

In another landmark case of Dr.Sr.Louise and others vs Srimathi Kannolil Pathuma, 1992, it was pointed out that heirs/legal representatives of a deceased consumer is entitled to file a complaint for such remedy. Other salient points from the judgment were that fee from room rent and treatment falls within the scope of the Act.

Professional Service Vs Personal Service

The medical profession repeatedly reiterated that the service of medical/dental work was of a personal nature.

The court differed in its view and said that doctors, lawyer, accountants, architects, surveyors and insurance agents have established themselves in society as professionals whose advice is sought in case of need and therefore the service rendered by them cannot be termed personal service. It would constitute professional service, which comes under the definition of service in Sec 2 (o) of the CP Act. In the case of medical or dental negligence it can be reported to the consumer redressal forum of territorial or pecuniary jurisdiction and if it is denied or disputed by

the doctor it will be defined under Sec2(e) as a 'consumer dispute'.

Nature of the Act

The CPA Act 1986 came into force in 1987 was ammended in 1993 and is now a three tier quasi-judicial machinery. It has

1. District Consumer Redressal Forum
2. State Consumer Redressal Forum
3. National Consumer Redressal Forum

The Consumer Protection Act 1986 is not a substitute for the existing civil remedies. The medical fraternity in particular has reacted a little excessively to the Act and many have perceived it as a tool of intimidation. It is only a fast lane judicial mechanism to enable speedy justice.

Aggrieved parties can still take recourse to the civil courts. This is particularly true of cases involving complex medical issues. In fact most cases involving medical or other technical issues have gone on appeal to appellate courts and many have been referred to civil courts.

Sec 3 of the Act says that the CPA is an additional facility and not a derogation of the provisions of other laws in force.

The Advantages of CP Act

1. It is totally free. There are no court fees.
2. Speedy justice. It has some disadvantages, particularly for the medical profession.
3. Procedural simplicity. Complainants can state their own case without a lawyer.
4. A non-intimidating atmosphere and encouragement to settle cases without too much of formality and lengthy procedures. Expert evidences can be taken in the form of affidavits and there is no need for experts to make

personal appearances. (The medical profession is of course not happy with this arrangement).

The Machinery

Consumer Protection Councils

These are established by notification of the government. There is a central consumer protection council and a state consumer protection council.

The central council will have a chairman (central minister in charge of consumer affairs) and members. It will meet at least once a year with the object of reviewing the rights of the consumer in respect to quality, quantity, potency, etc. of goods and services offered to him and to identify and correct unfair trade practices.

The state consumer protection councils have a state minister in charge as its chairman and other official and non-official members as prescribed. It shall meet not less than twice a year and review the status of consumers as in the central council.

The Consumer Disputes Redressal Agencies

The Act provides for establishment of a consumer dispute redressal forum. It has three levels of activity. The District forum (for each district) and the state forum are established by the state governments. The national consumer disputes redressal forum is established by the central government.

1. District forum (One or more district forum for each District).

One Retired or Sitting District Judge- President.

Two members of repute and integrity, one of shall be a woman: Jurisdiction upto Rs. 5 lacs (increased from Rs. 1 lac to Rs. 5 lacs in 1993.

2. State commission (one state commission for each state).

One sitting or retired judge of the High Court- President.

Two members of repute and integrity, one of whom shall be a woman.

Jurisdiction

1. Above Rs. 5 lacs and up to Rs. 20 lacs is its original jurisdiction.
2. All appeals arising from orders passed by any District Forum in the state.
3. Also has revisional powers and appellate jurisdiction (increased from Rs. 10 lacs to Rs. 20 lacs in 1993)

3. National Commission (one national commission for the entire country).

One sitting or retired Judge of the Supreme Court-president.

Four members of integrity and repute, one of whom shall be a woman.

1. Original jurisdiction: above Rs. 20 lacs and appellate jurisdiction (threshold limit was increased from Rs. 10 lacs to Rs. 20 lacs in 1993).
2. All appeals arising from orders passed by any State Commission.
3. Also have revisional powers.

The president and members are appointed by the state or central Government respectively on the recommendation of an appointed selection committee for each category.

An appeal against the order of National Commission lies to supreme court.

Who can File a Complaint?

- I. A consumer.
- II. Any voluntary consumer organization registered under the Societies Registration Act 1860 or under the

Companies Act 1956 or under any other law for the time being in force.

III. Central Government/State Government/Union Territory.

What Constitutes Service?

Honourable Supreme Court has in Indian Medical Association vs V.P. Shantha and Others III (1995) CPJ (SC) very lucidly explained the meaning and scope of “service” as follows:

The definition of ‘Service’ in section 2(1)(o) of the Act can be split into 3 parts the main part, the inclusionary part and the exclusionary part. The main part is explanatory in nature and defines ‘service’ to mean service of any description which is made available to the potential users. The inclusionary part expressly includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, board or lodging or both, housing construction, entertainment, amusement or the purveying of news or other information. The exclusionary part excludes rendering of any service free of charge or under a contract of personal service.

The apex court went on to examine coverage of medical services under the act and held that the medical practitioners belonging to medical profession are covered within the purview of the provisions of the act.

What Constitutes a Complaint? (only with regard to services)

Complaint means any allegation in writing by the complainant that he has suffered loss or damage due to deficient services. It can be related to deficiency, causing discomfort, loss of activity, loss of money, loss of work days, quality of life, etc.

‘Deficiency means any fault, imperfection or short-coming or inadequacy in quality, nature or manner of performance which is required to be maintained under any law for the time being in force or has been undertaken to be performed in pursuance to a contract or in relation to a service.’

As provided under Sec 24 A of Consumer Protection Act, a complaint has to be filed within 2 years from the date on which cause of action arises.

Where to File a Complaint?

A complaint should be filed in a district forum (subject to pecuniary jurisdiction) within the limits of whose jurisdiction all the opposite parties reside or carry on business, or any one of the opposite parties resides or carry on business (with the permission of district forum or acquiescence of the opposite party not residing there) or where the cause of action wholly or in part arises.

How to File a Complaint?

A complaint should contain the following information:

- a. Name and description and address of the complainant.
- b. Name, description and address of the opposite party or parties.
- c. The facts relating to complaint and when and where it arose.
- d. Documents, if any, in support of the allegation contained in the complaint.
- e. The relief, which the complainant is seeking.

The complainant or his authorized agent should sign the complaint.

PROCEDURE TO BE FOLLOWED BY CONSUMER FORUM UPON RECEIPT OF COMPLAINT

As per Sec.13 of CPA, first a copy of the complaint has to be sent to opposite party directing him to give his version

of the case within a period of THIRTY DAYS, which may be extended to FORTY FIVE DAYS.

The opposite party may deny the allegation or dispute the contention of the complaint.

The refusal of the opposite party has to be considered by consumer forum. In the event of not receiving the rebuttal within the stipulated time the consumer court can go ahead with the settlement of the case based on the evidence available.

- *Defect in goods:* (not relevant to medical negligence and therefore not discussed here)
- *Deficiency in service etc.*

The procedure laid is to refer a copy of the complaint to opposite party for its version to be submitted within *thirty* days or such extended time, but not exceeding *forty five* days all in all.

Dispute has to be settled after taking into account the version of opposite party and the evidence brought to the notice of the forum by the complainant and the opposite party.

Relief available to consumer:

- a. Refund of the price paid.
- b. Award of compensation for loss or injury suffered.
- c. Removal of deficiencies in service.
- d. To provide for adequate cost.

In the case of goods, replacement of goods, removal of hazardous substances et will also be imposed.

NATURE OF PROCEEDINGS BEFORE CONSUMER FORA:

It has all the powers of a civil court although it is only a quasi-judicial authority. The court can summon defendants (although they can be represented by their lawyers), witnesses, requisition laboratory reports, authorize tests etc. The consumer courts can take expert witnesses opinions as

affidavits (which the medical community has objected to) to save time.

Further, the proceedings before the consumer forums is deemed as judicial proceedings within the meaning of section 193 and 228 of I.P.C. and district forum is to be considered as civil court for purpose of section 195 and chapter XXVI of the Code of Criminal Procedure 1973.

Section 193 of Indian Penal Code pertains to perjury or fabrication of false evidence.

PUBLIC INTEREST COMPLAINTS

Subsection 6 of section 13 of the Consumer Protection Act covers this category of complaints, which may be called as public interest complaints or common interest complaints. This provision applies where there are numerous consumers having the same interest.

Order 1 Rule 8 of the Civil Procedure Code applies to such references

Procedure

This is a kind of representative complaint where one or more persons represent with the permission of consumer forum, all persons interested in the complaint. Consumer forum shall give notice of institution of complaint to all persons interested, at the expenses of the complainant. Forum may direct public advertisement instead of sending individual notice.

Any person for whose benefit the complaint is filed may apply to the forum to be made a party to the proceedings.

An order passed under these rules becomes binding on all persons on whose behalf or for whose benefit the complaint is instituted.

The above mentioned provisions have been incorporated when the Act was amended in 1993. As these provisions are very important for the public by and large there is a

need to stimulate development of the law and practices in actual working or operation of these scarcely used provisions of law.

Appeal against the Order of District Forum

- a. Appeal against the order of District Forum lies to the State Commission.
- b. Appeal has to be filed within 30 days.
- c. No fees have been prescribed for filing an appeal.
- d. Appeal should accompany a certified true copy of the Order of District Forum.
- e. Reasons for filing an appeal should be specified.

Similarly an appeal against the order of state Commission lies to National Commission.

Judicial Review of Procedures

Sub-section (3) of section 13 provides that no proceedings complying with the procedure laid down under sub-section (1) and (2) can be called in question in any court on the ground that, principal of natural justice have not been complied with. It appears judicial review in regard to the above aspects has been intentionally barred with a view to ensure speedy disposal of complaints which can otherwise be scuttled or delayed by innumerable vexatious proceedings before civil courts. While judicial review has been expressly barred, this section does not appear to bar writ jurisdiction of high courts. Further, an appeal or a revision petition can be filed before the appellate authority under the Act.

Time Limit Deciding Complaint/Appeal

As far as possible District Forum/State Commission/National Commission are required to decide the cases speedily i.e.

- a. Within a period of 3 months.
- b. From the date of receipt of notice by opposite party where the complaint does not require analysis or testing.

- c. Within a period of 5 months from the date of receipt of notice by opposite party where complaint required analysis or testing.
- d. National Commission and State Commission are required to decide the appeal as far as possible within 90 days from the date of 1st date of hearing.

Enforcement of Orders Passed by Consumer Fora

Enforcement and penal provisions in the Act enable the aggrieved complainant to enforce the orders of a consumer quickly and without any extra cost.

Salient Aspects of the Amendments to the Consumer Protection Act made on 17/12/2002 and effective from 15/3/2003

A number of amendments were made to the consumer Protection Act of 1986 (and amended in 1991 and 1993). The President gave his assent on 17-12-2002 after the Rajya Sabha passed it on 17-11-2002 (Act No 62 of 2002). These are effective from 15-3-2003. As these amendments are recent and have appeared in publication after going to press they have been added on.

Two proposals including one seeking to prohibit lawyers from appearing before the district Consumer Dispute Redressal for a State and National Commissions were dropped.

Definitions: A Complainant is 2 (b) IV—one or more consumers, where there are numerous consumers having the same interest may make a complaint.

2 (b) V—in case of death of a consumer, his legal heir or representative may also make a complaint. (Previously a legal representative of a deceased consumer could not make a complaint). *However in Dr Sr Louise Vs Kannollil Pathumma and others the Supreme Court had ruled that in*

case of medical negligence the legal heir or representative could make a complaint in medical negligence resulting in death.

Time Saving Measures

Adjournments have been curtailed (not more than one adjournment should be given).

Dodging of notices by opposite parties has been cleared by a newly inserted provision that says if notices have been received back with endorsement that the addressee had refused acceptance the forum shall declare the notice as served.

Reasons have to be recorded if decision is not given in 90 days. (Although 90 days were given for disposal of cases most cases took months and years to complete previously).

Revised Pecuniary Jurisdiction

District forum – up to Rs 20 lakhs (previous up to 5 lakhs).

State Commission – from Rs 20 lakhs to Rs 1 crore. (Previous up to 20 lakhs).

National Commission- from Rs 1 crore upward (Previous 20 lakhs and upwards).

Interim Order

The district forum can now give interim orders when damage is continuing as a relief. An order like stay can be passed, (It was not possible before).

Fees

The Consumer court will no longer be free. An yet undecided fee will be levied. It may be free for low value cases and poor people. Going on appeal will not be easy anymore. If the opposite party wants to go on appeal to state or

national commission, he must deposit 50% of the fees he has been ordered to pay or Rs 25,000/, whichever is less.

Punitive Damages

Section 14 gives powers to award punitive damages as a deterrent by imposing fines, stopping hazardous services, and asking to stop or change misleading advertisements.

FAQs

How is the consumer court different from a civil court?

Consumer courts are not bound by the extensive formalities governing other courts as they are fast track and quasi-judicial. The purpose of Consumer Courts is to dispense quick judgment. Plaintiffs do not have to pay court fees (except for a token amount in Supreme courts). However it is expected that a small court fee may be levied with the next amendment.

Can a consumer case be transferred to a civil court?

If there is substantial matter of law or fact (particularly technical facts), the case can be moved to a civil court at the instance of either parties.

Can a consumer case be filed against a government hospital?

Government hospitals are normally not liable under the Consumer Protection Act. It is because government hospitals do not charge fees and therefore are exempt. However if Government hospitals do charge a fee, then they are liable for deficiency of services.

Can a doctor/dentist file a case against the complainant?

The defendant (doctor/dentist) can file a case for defamation in a civil case if he finds that the intent of the patient was to malign his name. In a consumer case the court can award damages upto Rs 10,000 to the defendant if it thinks that the case filed was a frivolous or vexatious one.

Chapter 11

Ethics in Dentistry

Ethics in dentistry, as in any other sphere of human activity is governed by morals and social obligations to fellow beings. To understand the evolution of ethical considerations, it is important to understand the history of ethics. From the Indian perspective the ancient healers of India like Charaka and Susrutha had more than 3000 years ago laid down the obligations of health practitioners to their patients and to the community. However, it is the Hippocratic oath that is well known as one of the earliest ethical treatises.

THE OATH OF HIPPOCRATES

The Hippocratic Oath

I swear by Apollo the physician, by Aesculapius, Hygeia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgement the following oath:

“To consider dear to me as my parents him who taught me this art, to live in common with him and if necessary to share my goods with him, to look upon his children as my own brothers to teach them this art if they so desire without fee or written promise, to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction. I will prescribe regimens for the good of my patients according to my ability and my judgement and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice, which may cause his death. Nor, will I give a woman a pessary to procure abortion. But

I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest. I will leave this operation to be performed by practitioners (specialists in this art). In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all education, and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times, but if I swerve from it or violate it, may the reverse be my lot”.

The oath of Hippocrates was good for its times. However its relevance in the present is restricted, if not obsolete. In a multi-religious medical environment it would be absurd to swear by Appollo and Aesculapuis and Hygeia. Today’s doctors would laugh at the prospect of having to look upon his teachers children as his own or to teach them the art of medicine free of cost. Sentences such as ‘to no one will I prescribe a deadly drug’ will virtually leave the medical fraternity clueless, for every drug today is loaded with ‘deadly adverse effects’. The gynaecologist and the urologist will be constrained by oaths such as ‘nor will I give a woman a pessary to procure abortion’ and ‘I will not cut for stone’.

Declarations for guiding ethics in medicine have been proposed from time to time. While the Geneva declaration [modified in Sydney] gives broad outlines in ethical practices, The declaration of Tokyo 1975 adopted by the World Medical Association outlines ethics for doctors dealing with prisoners and detainees in war and peace.

The International Code of Ethics like the Geneva Convention gives a bunch of generalities. However, this code deals with some negative principles. They address the problem of what doctors *should not do*, such as self-advertisement and acceptance of commission for non-professional services.

Is the code of ethics a guiding principle that has an agent for enforcement or is it just another wish list that remains non-enforceable?

Ethical standards of the medical profession is seeing a steady decline, thanks to a market driven system that has ignored the altruistic concepts of the early teachers of the art. Today's corporate medicine and dentistry has degenerated to a common business practice whose concerns are strictly governed by profit and loss concerns. Even while this phenomenon has taken roots in our youngsters, there is emerging a new world order influencing health and healthy lifestyles. International health law is gaining relevance in a world that has become small due to increased international mobility and transport. An effective communication system has brought state of the world medicine to every one's doorstep. The flip side is a number of new pertinent ethical issues that technology has introduced. They include tissue transplantation, organ donations, genetic engineering and cloning and a host of other issues that go beyond the scope of this chapter on dental ethics. Issues such as human rights and universal rights to bodily integrity govern international health laws. The implementation and enhancement of the conceptual foundation of health laws is in its infancy. The United Nations' commission on human rights, the European Court of Human Rights and the World Health Organization are some of the groups working towards these goals.

Some of the well-known ethical norms and declarations are mentioned below.

1. Declaration of Geneva. (Amended in Sydney 1969).
2. Declaration of Tokyo, 1975.
3. International Code of Ethics and others.

Closer home, in India, we have some well-known Code of Ethics. They are:

1. The Code of Medical Ethics, 1972
2. The Dentists (Code of Ethics) Regulation, 1976.
3. The Homoeopathic Practitioners (Professional Conduct, Etiquette and Code of Ethics) Regulations, 1982.

Dental Code of Ethics, 1972

THE DENTISTS (CODE OF ETHICS) REGULATIONS, 1976

In exercise of the powers conferred by section 17-A of the Dentists Act, 1948 (16 of 1948) the Dental Council of India hereby makes the following regulations for laying down standards of professional conduct and etiquette or the Code of ethics for dentists, namely:-

Short Title and Commencement

1. These regulations may be called the Dentists (Code of Ethics) Regulations, 1976;
2. They shall come into force on the date of their publication in the official gazette.

Definitions

In these regulations, unless the context otherwise requires—

- a. “Act” means the Dentists Act, 1948 (16 of 1948).
- b. ‘Council’ means the Dental Council of India.
- c. All expressions used and not defined in these regulations shall have the meaning assigned to them in the Act.

Declaration

Every dentist who has been registered (either on Part A or Part B of the state dentists register) shall, within a period of thirty days from the date of commencement of these regulations, and every dentist who gets himself registered after the commencement of these regulations shall, within a period of thirty days from such registration, make before the Registrar of the State Dental Council a declaration in the form set out for purpose in the Schedule to these regulations and shall agree to abide by the same.

1. *Vide G.S.R. 1225, dated 2nd August, 1976*

Duties and Obligations of Dentists towards Patients and Public

Every dentist shall –

- a. Be mindful of the high character of his mission and the responsibilities he holds in the discharge of his professional duties and shall always remember that care of the patient and treatment of the disease depends upon the skill and prompt attention shown by him and always remembering that his personal reputation, professional ability and fidelity remain his best recommendations;
- b. Treat the welfare of the patient as paramount to all other considerations and shall conserve it to the utmost of his ability;
- c. Be courteous, sympathetic, friendly and helpful to and always ready to respond to the call of his patients and that under all conditions his behaviour towards his patients and the public shall be polite and dignified;
- d. Observe punctuality in fulfilling his appointments;
- e. Deem it a point of honour to adhere with as much uniformity as the varying circumstances may admit to the remuneration for professional services;

- f. Not permit consideration of religion, nationality, race, caste and creed, party politics or social standing to intervene in his duties towards his patients;
- g. Keep all the information of a personal nature which he comes to know about a patient directly or indirectly in the course of professional practice in utmost confidence and be mindful that the auxiliary staff viz., dental hygienist and dental mechanics and other staff employed by him also observe this rule for the reason that knowledge or information of a patient gained during the course of examination and treatment is privileged, and a dentist is not bound to disclose professional secrets, except with the consent of the patient, or on being ordered to do so by a court of law.

Duties of One Dentist Towards Another

Every dentist shall :

- a. Cherish a proper pride in his colleagues and shall not disparage them either by actions, deeds or words;
- b. On no account contemplate or do anything harmful to the interest of the members of the fraternity;
- c. Honour mutual arrangements made regarding remuneration, etc., when one dentist is entrusted with the care of a patient of another dentist during the latter's sickness or absence;
- d. Retire in favour of the regular dentist, after the emergency is over, when a dentist called upon in any emergency to treat the patient of another dentist;
- e. Institute correct treatment at once, with the least comment, and in a manner that will avoid any reflection on such other dentist, if a dentist is consulted by a patient of another dentist, and if the latter finds indisputable evidence that such a patient is suffering from previous faulty treatment;

- f. Regard it as a pleasure and privilege to render gratuitous service to another dentist, his wife and family members, although there is no legal bar to a dentist from charging another dentist for professional service.

Note: He shall be entitled to charge the patient for his services.

Unethical Practices

The following shall be the unethical practices for dentists, namely:

- a. Employment by a dentist in his professional practice of any professional assistant (not being a registered dental hygienist or a registered dental mechanic whose name is not registered in the state dentists register, to practice dentistry as defined in clause (d) of section 3 of the Act;
- b. Styling by any dentist or a group of dentist his/their dental clinic or chambers by the name of dental hospitals;
- c. Any contravention of the Drugs and Cosmetics Act, 1940 (23 of 1940) and the rules made thereunder as amended from time to time, involving an abuse of privileges conferred thereunder upon a dentist, whether such contravention has been the subject of criminal proceedings or not;
- d. Signing under his name and authority any certificate which is untrue, misleading or improper, or giving false certificates or testimonials directly or indirectly concerning the supposed virtues of secret therapeutic agents or medicines;
- e. Immorality involving abuse of professional relationship;
- f. Conniving at or aiding in any kind of illegal practice;
- g. Promise of radical cure by the employment of secret methods of treatment;

- h. Advertising where directly or indirectly for the purpose of obtaining patients or promoting his own professional advantage;
- i. Acquiescing in the publication of notice commending or directing attention to the practitioner's skill, knowledge, service or qualifications, or of being associated with or employed by those who procure or sanction such advertising or publication through press reports;
- j. Employing any agent or canvasser for the purpose of obtaining patients, or being associated with or employed by those who procure or sanction such employment;
- k. Using or exhibition of any sign or other a sign which in its character, position, size and wording is merely such as may reasonably be required to indicate to persons seeking them the exact location of, and entrance to, the premises at which the dental practice is carried on;
- l. Using of sign-boards larger than 0.9 metres by 0.6 metre and the use of such words as "Teeth", "Painless Extraction" or the like, or notices in regard to practices on premises other than those in which a practice is actually carried on, or show cases, of licensing light signs, and the use of any sign showing any matter other than his name and qualification as defined under clause (j) of section 2 of the Act;
- m. Affixing a sign-board on a chemist's shop or in places where the dentist does not reside or work;
- n. Insertion of any paragraphs and notice in the press and also the announcement of names in the trading lists and the display of their names or announcement at places of public entertainments, other than the change of his address;
- o. Allowing the dentist's name to be used to designate commercial articles such as tooth paste, tooth brush,

tooth powder, liquid cleaners, or the like or on circulars for such items, or permitting publication of his opinion or any such items, in the general or lay papers or lay journals;

- p. Mentioning after the dentist's name any other abbreviation except those indicating dental qualifications as earned by him during his academic career in dentistry and which conform to the definition of 'recognised dental qualification' as defined in clause (j) of section 2 of the Act, or any other recognised academic qualifications;
- q. Using of abbreviations like (i) R.D.P. for Registered Dental Practitioner, (ii) M.I.D.A. for Member Indian Dental Association; (iii) F.I.C.D. for Fellow of International College of Dentist, (iv) M.I.C.D. for Master of International College of Dentists, (v) F.A.C.D. for Fellow of American College of Dentists, (vi) M.R.S.H. for Member of Royal Society of Hygiene, etc., and the like which are not academic qualifications.

Change of Address and Announcement Relating thereto –

- 1. A notice for the change of address shall be intimated to the concerned State Dental Council;
- 2. A dentists may issue a formal announcement in the press, one insertion per paper, regarding the following, namely;-
 - a. On starting practice;
 - b. On change of type of practice;
 - c. On changing address;
 - d. On temporary absence from duty;
 - e. On resumption of practice;
 - f. On succeeding to another practice.

Action for Unethical Conduct

When a complaint or information is received by the State Dental Council that any dentist is resorting to any unethical practice as mentioned in Regulation 6, or is committing a breach of any other of these regulations, the concerned State Dental Council may call upon him to explain and after giving him a reasonable opportunity of being heard and after making such enquiries, if any as it may, deem fit, decide whether such practices are tantamount to infamous conduct in any professional respect or contravenes any of the provisions of any other of these regulations, and then determine the action to be taken against the dentist under section 41 of the Act.

As and when a complaint of breach of these regulations is brought to the notice of the Registrar of a State Dental Council, he shall take prompt action.

FAQs

Can a dentist be punished for violation of ethics?

Theoretically yes! However, neither, the state government, central government nor the DCI/MCI has resorted to this action. It is one of the reasons why there is open flaunting of medical and dental ethics in practice.

Is using a Red Cross to indicate a doctor's clinic or car allowed by law?

A Red Cross to indicate a medical or dental practitioner should not be used. It can be used only by the International Red Cross or the armed forces (in combat) to indicate a military health facility. Use of a Red Cross by a private doctor can invite a fine upto Rs 500.

Is television publicity allowed ethically?

The Code of Ethics, prohibit publicity in the press and any other mass media, including the electronic media. The exceptions to the rule are mentioned in the text. It is common place to see extensive television publicity in the name of information by doctors, dentists and quacks.

What abbreviations are allowed after a dentist's name to indicate his qualifications?

The only abbreviations allowed after a dentist's name are those qualifications (degrees and diplomas) that have been obtained in a university or recognized examination board at a convocation. Non-examination memberships and fellowships in associations, institutions and non-academic colleges including FICD, FRSH, FPFA, FAGE, etc are not allowed. It is another matter that many leaders of the profession including senior members of the council flaunt these so called qualifications!

Is it ethical to receive money from the client when asked to appear as an expert witness?

The court stipulates that the expert witnesses expenditure should be borne by the party calling them. It, therefore, appears ethical to receive fair compensation for travel, stay, food and loss of professional income.

Chapter 12

Insurance against Disability: Dental Perspective

Risk is a part of human life. All activities have a certain element of risk involved.

The concept of insurance is meant to affect these anticipated risks.

What is Insurance?

It may be defined as a legal device where one party, called the insurer undertakes to absolve another (the insured), either wholly or partly from loss or liability, which the latter may incur in certain eventualities.

The insurer undertakes to pay to the assured or his assignees or nominees certain sum of money or its equivalent on the happening of certain events. The “happening” may be an accident, theft, burglary, illness or death.

The promise of the insurer to compensate the insured is a conditional one. The compensation is paid only if the condition specified in the undertaking happens. The promise is not a gratuitous one. The insurer undertakes to compensate the assured only in return for the payment of a sum of money called the **premium** by the latter.

Insurance and the Dentist

The dentist is often involved with the insurance agencies. He may be involved in four ways.

1. As an insured party with regard to insurance against damage to dental equipment or his clinic.
2. As recipient of fees from insurance companies with whom his patients might have been insured for possible dental health needs.

3. Professional indemnity against medical negligence claims by patients.
4. As an evidentiary expert in trials involving claims for dental or maxillofacial injury.

Essentials of an Insurance

1. *The Policy*: It is the document containing the contract of insurance.
2. *Contract of Good Faith*: Unlike regular contracts, the contract of insurance is a contract of “good faith”. All material or relevant risk must be disclosed to the insurer or else it is void, e.g. a person taking life insurance must disclose all relevant medical history, particularly those that may affect longevity of life, e.g. previous heart attacks, treatment for cancer, etc.

Types of Insurance

1. Life insurance
2. Fire insurance
3. Burglary insurance
4. Medical insurance
5. Motor vehicle insurance
6. Medical indemnity

Only the insurance relevant to dentistry and the dentist will be discussed.

Medical Insurance

The insurer pays for hospitalization or treatment that is covered by the policy. The policies have several conditions including exclusion of certain kinds of treatment. Dental treatment is usually not covered by the existing medical insurances in India. However, surgical problems in dentistry, particularly maxillofacial trauma and infection are covered

by the insurance. Dental treatment is covered by insurance schemes in many western countries. Premium for coverage of dental treatment is usually high.

Motor Vehicle Insurance

The risk of liability or loss in connection with the use of a motor vehicle is covered by this insurance. The insurance covers,

- i. Damage to vehicles
- ii. Injury or death of persons who possess or drive the motor vehicle. The death or injury may be to the assured, his driver, family or to third parties. Third parties are covered compulsorily by an insurance policy that is binding on the owners of the vehicle. It is called '**third party** insurance'.

The liability of the owner of a motor vehicle towards third parties is called a "Strict Liability".

Third Party Insurance

The owner of a motor vehicle is legally bound to cover through an insurance policy, his potential liability to third parties arising out of the use of the vehicle in public places. The liability that is so covered is in respect of injury or death to third parties. The Insurance is compulsory so that claims of a victim of an accident is not defeated by financial incapacity.

Doctors and dentists can advise patients with road traffic accidents on the insurance benefits accruing to them even if they are the victims of an accident irrespective of whether the injury was caused due to their own negligence or not.

Claims Tribunal

The Motor Vehicles Act 1988 provides for a Motor Accidents Claim Tribunal to facilitate cheap and speedy disposal of claims arising out of motor accidents.

A person can file an application for compensation within six months of accident.

The persons entitled are,

1. Persons who sustain injury or loss
2. Legal representatives of persons killed in an accident.
3. An agent of the victim in an accident.

The tribunal gives an award, which can be appealed against.

The introduction of the Motor Vehicles Tribunal has speeded up compensation for those involved in motor vehicle accidents. Doctors/dentists are now rarely called upon to appear in courts as expert witnesses.

Accident Compensation Laws

The Fatal Accident Act 1855

The Motor Vehicle Act 1988

The Factories Act 1948

The Workmen's Compensation Act 1923

The compensation laws lay down the minimum compensation in case of death and permanent disability. While it is up to the judiciary to decide on what is 'just compensation' and whether there was negligence on the part of the victim or not, the doctor/dentist is often called upon to give details of injury and quantify it. The method adopted may take into account varying factors including age, occupation and the kind of disability.

Injuries to the face can cause deformity and disability. The dentist may be called upon to give certification as to the extent of disability/deformity an individual may have in the dentofacial region.

While there exists numerous criteria in India for evaluation of permanent disability in orthopedics, neurology and other areas there is no functional disability criteria for dentistry and the maxillofacial region. Some of the common references for disability for the purpose of quantification of injuries to various parts of the body are:

1. Manual for doctors to evaluate permanent physical impairment – Based on Expert groups meeting on disability evaluation and National Seminar on Disability – DGHS – WHO – AIIMS, New Delhi – 1981.
2. Uniform disability of physically handicapped, Government of India, Ministry of Welfare, 1986, Gazette of India, Part I Section I No. 4 –2/83HWIII.

These manuals do not indicate clearly the disability/deformity caused in the dentofacial region.

Some international references may be found in

1. McBride, Earl D:- Disability Evaluation J.Int.Surg 1955; 24:341-348.
2. Guidelines to the evaluation of Impairment of the Oral and Maxillofacial Region AOMSI – 1997.

This author's proposed disability criteria are mentioned in Chapter 18. It may be used as an interim criteria in view of the absence of a comprehensive disability/deformity criteria in India.

The possibility of the insurance sector in India opening up to global companies, will attract many players to enter the medical and dental sectors in a big way. It is important that the dental surgeon familiarizes himself with insurance laws and procedures, as he may have to do business with them in the future.

New rules and policies make it difficult to discuss the finer aspects of insurance procedures. The reader is

encouraged to read the policy details issued by individual companies.

FAQ

If a negligent act by a doctor occurs one day after the expiry of a professional indemnity insurance, will the insurance company pay?

No! The insurance company will not indemnify the dentist. Always remember to renew your practitioner's indemnity policy.

Chapter 13

Medical and Dental Negligence in Other Countries

One of the main reasons given by the supreme court for bringing the service of professionals into the ambit of the Consumer Protection Act was the absence of a statutory regulating board or authority that could effectively regulate and penalize doctors/dentists for negligence or professional misdemeanor. It is interesting to note that in the decades of existence of the medical and dental councils, there has rarely been any case of action taken against doctor's or dentist's for professional misconduct.

Many legal and medical luminaries are of the view that rather than roundly oppose the inclusion of the medical and dental professions under the CP Act, the professional bodies should have proposed a viable alternative in the form of a proactive professional disciplinary committee to strictly regulate the practice of the profession and mete out stringent punishment when required. It is naïve on the part of our professionals to think and argue that doctors and dentists cannot make mistakes and that they should not be punished for the same.

Summarized below is the report of disciplinary action taken by a dental professional tribunal for one quarter in New Zealand.

New Zealand Dental Tribunal

Five practitioners appeared before the tribunal in the period ending June 1998.

- A patient complained that during a two-year period the dentist's provision of root filling work was defective in

that in two teeth, canals were perforated and one post inserted was too short to withstand normal stresses. The patient further alleged that the treatment resulted in the loss of two teeth as a result of the perforations and the loss of a further tooth as a result of the vertical fracture of the root caused by the inadequate post. *The tribunal found the charges established a professional misconduct and ordered that the practitioner be censured, pay a fine of \$1,000, undergo supervision in respect of his next 12 crown and bridge cases and pay 20 percent of the hearing costs.*

- A patient complained that the dentist had used instruments that were overheated (whether by failure to use adequate cooling fluid or otherwise) and that the use of overheated instruments had caused the loss of some of her teeth. *Following a hearing before the Tribunal none of the charges were found to be proven.*
- A three-day hearing before the tribunal considered charges against a dentist arising out of his extraction of a tooth and complications that followed. It was alleged that rather than undertaking the exploration and debridement of the socket the dentist should have referred the patient to an oral surgeon and that the treatment given resulted in damage to the inferior dental nerve causing a number of problems for the patient.

Evidence in this case was heard by video linkage from three expert witnesses based in the United States. *The tribunal found the charges proven and ordered that the practitioner be censured, fined \$1500, and pay 30 percent of the hearing costs. The decision of the tribunal has been appealed to the High Court.*

- A dentist faced allegations arising out of his use of a ceramic restoration system. The patient alleged that the dentist failed to carry out treatment to an acceptable

standard and in particular that as a result of the treatment she experienced severe hypersensitivity of all her teeth with the possibility of further endodontic work being required and that she suffered the loss of one tooth. The patient further alleged that the dentist failed to follow-up on a complaint made by her previously. *Following a hearing before the tribunal none of the charges was found to be proven.*

- A senior practitioner was charged with failing to provide a report for a patient despite repeated requests by the patient, her GP and ACC. The dentist admitted the facts and the tribunal found the charges proven. *The dentist was fined \$1,000 and ordered to pay 30 percent of the hearing costs.*

The above examples seem a fair justification to establish such tribunals or statutory bodies to supervise the quality of dental treatment.

American Law of Malpractice

In the USA medical malpractice has been defined as the failure of a medical professional to meet the standard of 'good medical practice'. Medical professionals include physicians, dentists, physiotherapists, nurses and other health care providers.

The term medical malpractice in the USA has a broader meaning than negligence as discussed in the Indian or UK context. The concept of 'negligence per se' (similar to *Res Ipsa Loquitor*) is widely accepted and medical expert testimonies are sometimes not always required. Consent is a major requirement in the USA and most doctors and dentists provide elaborate consent forms. Issues such as confidentiality and patient autonomy are serious matters and breach of these can invite malpractice suits.

The American legal system differs significantly from the Indian system, particularly in respect to legal procedures. Some of the features are:

Deposition

Unlike in India the discovery method includes deposition. In this session a witness will provide testimony in a question and answer format. It is provided under oath just as in open court during trial. The judge is not present but a court reporter will record the proceedings and give a copy of the transcripts to the attorneys of both parties.

Settlements

Most cases do not reach the trial stage and are settled voluntarily or by court order. Only a small percentage of cases go to the trial stage.

After many months of discovery the case may go to trial. All parties present their cases to the jury in the presence of a judge and the jury will decide on the basis of facts. Unlike in India, the judge only decides on issues of law and generally oversees the trial, often deciding on what may be admissible as evidence and what may not be admissible.

The Jury

The jury consists of ordinary citizens who may be called up for jury duty. They go through a process of jury selection, when the attorneys of both sides have an opportunity to question the prospective juries and eventually select them through a complex procedure of consensus.

The Trial

The plaintiff's and defendant's attorneys present their cases with witnesses including experts in the field. The jury then deliberates before giving a verdict. The judge advises the

jury on matters of law and evidence throughout the course of the trial. The jury will remain incommunicado to the outside world throughout the period of the trial.

The jury will finally give a verdict.

Appeal

Appeals will lie to the court of appeals and will be accepted only on issues of law.

The American system gives a lot of importance to the decisions of a jury.

The American Dental Association

The American Dental Association is autonomous and empowered to take punitive action against erring dental professionals. They exercise this authority very seriously, unlike their Indian counterparts.

United Kingdom

India has borrowed significantly from the UK legal system. This is particularly true of the laws pertaining to civil medical negligence. The NHS (National Health Service) depends on the 'Bolam Test' as a test for medical negligence and standard of medical care. The Indian negligence laws are quite similar to those in the UK.

The General Medical Council and The General Dental Council of the UK are powerful bodies with statutory powers to take penal action against doctors and dentists respectively.

It is compulsory for all doctors and dentists in private practice to be members of the medical or dental defense unions, who will insure them against malpractice suits. Doctors and dentists working in the NHS are usually covered by the NHS for suits for negligence. The NHS may however investigate and take action for negligence by its doctors or dentists.

Chapter 14

Ethical and Legal Principles in Treatment of HIV Patients

Today HIV/AIDS has become a genuine concern in the general population. It acquires greater importance for the health care professional as he is more likely to confront the disease on an intimate level. Dentists are often confronted with ethical dilemmas in dealing with HIV/AIDS patients.

Testing for HIV/AIDS

HIV can be tested and monitored by these broad techniques:

1. Detection of antibody
2. Detection of antigen
3. Detect or monitor viral nucleic acids
4. T-Lymphocyte estimation.

The most common techniques used are detection of antibodies. This is an important fact. The test may show positive reaction to antibodies for other biological conditions as well. In other words, there is a possibility of false positives. This has important legal and ethical implications.

HIV/AIDS also has significant social taboo attached to it. In addition to being a crippling and fatal condition, the possibility of social stigmatization is an important consideration.

Bearing the above in mind, it is important to view HIV/AIDS testing in a different light. Infection with HIV virus brings into conflict the individuals right to limit knowledge of his condition with the necessity to make it known to those concerned.

In the leading case of **Dr. T Vs. Apollo Hospital**, a person with HIV status fought to prevent his status being informed to his fiancée. The NCDRC ruled that there was no violation of rights in the act of divulgence if the circumstances warranted it. However, we might wish to know for what purpose one needs to test a patient for HIV/AIDS.

Is it for epidemiology?

Is it for targeting high-risk category for counseling?

Is it to prevent spread?

Is it for the health professional's benefit?

While the first three questions may have relevance the last is for the dentist's benefit, for which the patient pays. Is it ethical?

HIV/AIDS testing may therefore have two approaches

a. Mandatory

b. Voluntary

From the human rights perspective, mandatory testing is wrong. It is against law and ethics of medicine. The word 'mandatory' itself is suggestive. However, it is used in certain situations where there are tremendous risks to others, such as blood donation. Routine testing without consent of patient is unethical and violative of patient's rights. Dentists, who wish to do so, should do it only after obtaining an informed consent. The test should be accompanied by pre and post test counseling in an approved testing facility. The patient should be warned of false positives, window periods and given details of further confirmatory tests if warranted.

Details of HIV status are not to be divulged to others unless there are pressing circumstances or to pre-empt hazardous activity by the patient.

Dentists must understand that the HIV/AIDS testing must be done with consent only when absolutely warranted.

Breach of these conditions can invite legal and ethical sanctions.

Treating HIV/AIDS Patients

Modern dentistry aims at practicing universal precaution against communicable diseases. These include hepatitis B, hepatitis C, AIDS, methicillin resistant staphylococcal Infection (MRSI) etc. Prevention of infection should not be restricted to only the health provider. It is the dentist's responsibility to prevent cross infection between patients. Standard infection control protocols must be practiced in all clinical situations. Endangering the health or lives of other patients (even without injury) can invite criminal negligence (Sec 336 IPC). In case of proven cross infection it can make the dentist liable under civil and criminal laws.

Stuart L. Fischman says this about dental treatment considerations in HIV patients:

“As health care professionals, dentists have the moral, ethical and legal obligation to attend to the oral health needs of all patients. The “healthy” HIV infected patient with a CD-4 count above 200 can usually receive routine dental treatment in the office of a general practitioner. No special procedures — only universal precautions — are required. Referral to a specialist is indicated, depending on the generalist's customary scope of practice, in a manner identical to that for the non-HIV infected patient. For example, management of oral candidiasis and of periodontal disease is within the scope of practice of most general dentists. When the patient has a low CD-4 count (below 200) or presents with severe ulcerations or Kaposi's sarcoma, referral may be indicated. A patient's HIV status is confidential information, but an important part of the anamnesis. It should be obtained in every health history, but it must not be used as a “barrier” to access to dental

care. It is privileged information and must not be disclosed by the dentist or office staff. Medical colleagues must share all health information with professional associates, but confidentiality must be assured within the health care community. Referral of dental patients for HIV testing must be done judiciously and consistent with oral health findings — *it should not be a dental screening procedure.*”

The standards in legal and ethical practice should be to keep in mind:

1. Universal precautions
2. Medical consultation.

A leading case on this issue before the US courts is referred to as **the Bragdon case(1994)**.

“In a nutshell, the court ruled that Sidney Abbott, an asymptomatic person with HIV, was protected by the provisions of the ADA (Americans with Disability) and that her rights may have been violated in September, 1994 when a local dentist, Randon Bragdon, refused to fill a cavity discovered during a routine dental examination at his office in Bangor, Maine. She had disclosed in an office questionnaire her HIV-positivity, and the dentist declined to perform the simple procedure in his office on that basis. Citing his concerns as to “infection control,” he offered to do the work in a local hospital at no extra charge for his services, but explained that she would be responsible for any additional fees charged by the hospital.

Reading between the lines, it is clear that Abbott was hurt and angered by Dr. Bragdon’s actions, and felt that he was simply trying to get rid of her, or “dump her” as a patient, because she was HIV-positive. (It was later noted in the record, for example, that the dentist had enjoyed no privileges with local hospitals at the time of his offer. Apparently furious about her inability to get simple medical treatment on the same terms as other patients, Abbott

declined the dentist's offer and instead proceeded to sue him in federal court, arguing a violation of her rights under state and federal law. In the ensuing litigation, Dr. Bragdon countered in the lower courts with two primary arguments.

First, he argued that the patient's HIV-positivity, in the absence of any visible symptoms or illness, failed to qualify for protection as a defined "disability" under the ADA. If she showed no signs of illness, he contended, how could she be possibly be "substantially impaired" as required for protection under that law? As a backup argument, he contended that his refusal to render treatment was justified under ADA language excepting from its protections any services "posing a direct threat to the health and safety of others." In other words, he believed that filling the cavity could expose him or other patients to the risk of HIV infection, and that this fear justified his action."

In both lower federal courts, Abbott prevailed completely as each accepted her arguments. It was struck down in the supreme court on technical issues.

The Indian context is effectively put forward by Mandeep Dhaliwal at the 5th International Congress on AIDS in Asia:

Health Care Discrimination in India

- Mandeep Dhaliwal (Fondation du present)

"In India, people living with HIV/AIDS most often face discrimination in the area of health care. Discrimination in the health care sector wears many faces:

- *Denial of medical treatment — Lawyers Collective HIV/AIDS Unit, an NGO providing legal aid, advice and support services to those affected by HIV/AIDS has anecdotal data of as many as five incidents per week of HIV-positive persons being denied treatment solely because of their HIV-positive status. This seems to be the most common form of health care-related discrimination.*

- *Inappropriate medical treatment — delays in treatment, shunting from department to department, refusal to perform invasive procedures, refusal to provide medical records*
- *Early discharge*
- *Isolation in hospital wards*
- *Conditional treatment — treatment in exchange for participation in research studies*
- *Biased comments and prejudiced behaviour — value judgements about the patient*

According to the law in India, the right to health is a fundamental right under Article 21 of the Constitution of India. Fundamental rights are available only against the state viz. public sector health care institutions/providers. Therefore, public sector hospitals cannot refuse to treat someone because they are HIV-positive. However, discrimination against people living with HIV/AIDS specifically in the form of denial of treatment in public hospitals is all too common.

It is a well-known fact that private medical establishments/providers do not treat patients who are known to be sero-positive. Legally, there is no obligation for private health care institutions/practitioners to provide treatment to any person except in the case of an emergency (*Parmanand Kataria vs. Union of India*, AIR 1979 SC 2039).

According to national sample study conducted by the National Council for Applied Economic Research, 60 - 80% of health care is sought in the private sector. Given the large numbers of people living with HIV/AIDS in India, the already over-stretched public health care system will not be able to cope and there will be an ever-increasing burden on the private health care system to provide treatment for people living with HIV/AIDS.

To sensitize private practitioners to issues relating to HIV/AIDS with a view to improving the access to health care for people living with HIV/AIDS, the Mumbai District AIDS Control Society is providing comprehensive training programmes for private practitioners throughout the region of Mumbai. The training programme covers a gamut of topics including epidemiology, clinical management, infection control measures, universal precautions, counselling, blood/blood product safety, legal and ethical issues etc. The sessions are being well received by the community of private medical practitioners.”

Mandeep Dhaliwal

Key correspondent (India)

Fondation du Present

In summary it might be said that while private practitioners may refuse treatment legally, moral and ethical principles require them to treat HIV/AIDS patients without discrimination.

Government and public health care professionals are duty bound to treat and HIV/AIDS patients can take recourse to constitutional means to enforce this obligation under Art 21 of the Indian constitution (Right to life).

Chapter 15

Miscellaneous Legal and Ethical Issues

THE ETHICS OF EXPERIMENTATION IN DENTAL PRACTICE

This does not deal with dental research but with trials of new techniques and materials. It is important to use the dictum 'Primum non nocere' (above all, cause no harm). This situation deals with treating patients in an ethical fashion when there is no guarantee of success.

There are four ethical standards for experimenting in practice.

1. The action is aimed at benefit for the patient.
2. It falls within the accepted standard of care.
3. There is evidence of success in the procedure.
4. The action is performed systematically and with measured outcome.

All of the above are done taking into account the patients interest. This takes precedence over the risks to the dentist/surgeon or the practice, both of which can also suffer in the process of experimentation. In this context, it is important to have an informed consent from the patient.

The common ethical principles are based on

1. Autonomy
2. Beneficence
3. Competence
4. Integrity
5. Justice
6. Non-maleficence
7. Veracity

Autonomy

The right of the patient, the dentist, and any other competent individual who is involved to determine what should be done by and to them.

Beneficence

An obligation to help others, normally assumed in exchange for privileges to granted a group such as professionals.

Competence

The capacity to perform as one promises or as expected.

Integrity

Consistency throughout one's actions and language, being guided core values.

Justice

Fairness in the distribution of rewards and obligations and in the processes by which distribution is made; Sometimes, tested by a willingness to trade places with whom one deals with.

Non-maleficance

Avoiding unnecessary harm to others.

Veracity

Telling the truth and creating environments where honest views are expressed.

An Illustrative leading case on experimentation is:

Karp vs. Cooley 493 F 2d 408 (1974)

The famous cardiothoracic surgeon Denton Cooley had to face a malpractice suit when he implanted the first

mechanized heart into Mr Karp for failure to disclose possibilities of failure.

QUACKERY IN DENTISTRY (Unlicensed Practice)

The concise Oxford dictionary, describes a quack as a person who is an “ignorant pretender to skill, especially in medicine or surgery.”

Unfortunately dentistry is one of the specialties with the largest number of quacks. India became independent in 1947. The dentists Act was promulgated in 1948. Before the dentists Act of 1948, there were no rigid regulations governing the dentists practicing in India. The first dentist's register was prepared with two categories of Dentists-Part A and Part B. Part A dentists were those with LDS or BDS qualification from an University or recognized board. Part B dentists were those who had practiced dentistry for at least five years in that place as their sole livelihood. Both groups were allowed to register as dentists under the Act. In the eyes of the law Part A and Part B dentists are equal. The first register prepared by the tribunal was closed in 1950 in the whole of India to Part B practitioners. Goa, Pondicherry and some other regions became independent from French and Portuguese rule later and merged with the Indian Union only in the sixties. These union territories were allowed to register Part B dentists for a fixed period of time. In Pondicherry the register was officially closed in 1965. However, the government chose to re-open the register for Part B dentists in 1972 and again in 1983 allowing numerous unqualified persons to register in Part B schedule. This was done despite the objections from the Ministry of Health, Government of India and the Dental Council of India. There was uproar in the Pondicherry assembly and in the dental fraternity-but to no avail. The Indian Dental Association has been waging a relentless war

against quackery. The first Pondicherry affair committee was formed by the IDA, with Dr Samraj as the convenor. Subsequently, Dr Veerabahu became the convenor. They made numerous representations to the governor and the Pondicherry government. The Pondicherry government gave temporary registration to dentists who were then given permanent registration on completing five years. This was supposed to be given only to those persons who had two years domicile in Pondicherry and the registration allowed them to practice only in Pondicherry. The Pondicherry registered dentists, however, practiced in all the neighboring states as well. Technically, this is against the rules.

In addition to this many persons practiced dentistry with no qualification or registration of any kind. The dental profession, particularly the IDA, (like the medical profession) has been waging a losing battle against quackery with little or no effect. The main reason for this failure is the lack of legal authority for the DCI and MCI to deal with these practitioners. The quacks are politically powerful and have successfully thwarted the attempts of the professional associations. Very few quacks have been apprehended and punished.

An unqualified person is one who:

1. Offers services permitted only by a licensed professional.
2. Pretends to have a professional license when he does not have one.
3. Uses a title or degree when he does not possess it.

Individuals of different system of practice such as Homoeopathy, Siddha and Ayurveda sometimes practice Allopathy. This is also quackery.

Quacks can be penalized under the following laws:

- Indian Medical Degrees Act 1916
- The Dentists Act 1948.

- Medical Council Act 1956.
- Drugs and Cosmetics Act 1940.
- Drugs and Magic Remedies Act (objectionable advertisement) 1954.

Alternate medical systems are governed by Acts, which specifically prohibit them from practicing allopathy. These include:

- Indian Medicine Central Act 1970
- Homoeopathy Medical Practice Act 1970

If Quacks (unqualified persons) cause death or injury the cases can be criminal and civil. The criminal laws are stringent when unqualified persons cause injury.

Kalyanlal Ramlal Trivedi vs. Satyanarayana Viswakarma I (1997) CPJ 332

A person with toothache was seen by a 'doctor' who claimed to be a doctor in the integral 'medical system'. He had no formal qualification in medicine or dentistry. He was administered steroid injections for many days resulting in infection and death. The patient was awarded Rs 2,00,000 and was referred to the authorities to face criminal charges as well.

In Poonam Verma vs. Ashwin Patel, 11 (1996) CPJ 1 SC

It was held that a homoeopathic practitioner practicing allopathy commits an act of "per se" negligence and is liable to pay compensation to the aggrieved person.

Quackery is a curse on the health needs of the public. The medical and dental community should join hands and give support to the cause espoused by people like Dr V.M. Veerabahu in bringing the issue of quackery to the notice of the lay public and the authorities.

PROFESSIONAL-CLIENT SEXUAL CONTACT

In American law this comes as part of malpractice and professional misdemeanor. Studies have shown that dentists are high-up in the list of professionals with propensity for professional-patient sexual contact.

The professional is often in a position of greater power in a professional-patient relationship. It is a kind of fiduciary relationship. The patient is usually the one who is affected by this contact. At the minimum it is gross ethical misconduct. In India, if the relationship is by mutual consent, very little can be done through the legal process. In the USA, the courts are following this trend and holding physicians, dentists and lawyers for harm caused by sexual contact to patients by exploiting fiduciary relationship. More and more patients harmed psychologically or otherwise are seeking redress in courts for civil suits for money and sometimes even criminal sanctions and licensing board actions.

In India if the doctor/dentist indulges in non-consenting sexual behaviour, he can be charged under criminal law. Unfortunately, very few cases are reported due to social pressures and even when they are reported, the charges are difficult to prove. The licensing agencies like the dental council cannot take up suo moto action and will necessarily wait for conviction before contemplating any action.

CONFIDENTIALITY

It is ethically and legally binding that information from the patient to the doctor/dentist is kept confidential. It is called **privileged information** and may not be released to others, not concerned with it. Information can of course be shared between consultants and staff when necessary.

However, in some situations breach of confidentiality is permitted in the public interest. This situation should be assessed properly and used only if it is legally binding.

Forensic Odontology

INTRODUCTION

Forensic odontology has become an important adjunct of forensic medicine. The calcified structures of the tooth often survive the most destructive elements and are sometimes the only clue available in forensic investigations. The forensic odontologist is part of a multidisciplinary team, which may contain law enforcement officials, forensic pathologists, forensic anthropologists, serologists, genetists, criminologists and others. Like all subjects, forensic odontology has benefited from the rapid strides made by science and technology. Forensic science today encompasses a broad sphere of activity, which includes investigation of bite marks, saliva and pulp tissue in addition to the calcified structures of teeth.

Around the world a considerable number of individuals disappear every year. Some of them are later found dead, leaving no trace as to their identity. This state of affairs is magnified by large-scale accidents such as air or earthquake disasters. In case of murder, it is often of crucial importance to identify the victim before searching for the murderer. In modern society another important reason for identification of dead bodies is to satisfy the requirements for a death certificate. Apart from the requirements of law, relatives commonly have a strong personal wish to be satisfied as to the fate of kinsman.

The application of official medical and other scientific investigation techniques to the field of criminal law is not a new concept but many communities have never actually tried to incorporate sophisticated dental knowledge in criminal investigation.

What Louis Pasteur once said, holds true even today; “in the field of observation chance favors the mind that is prepared”. Likewise, a scientifically prepared mind with the knowledge and experience of odontology, if applied in criminal observations can solve medico-legal problems. In recent times forensic odontology has evolved as a new ray of hope in assisting forensic medicine. This is a relatively young branch of dentistry and still in its infancy in our country. . The significant role of forensic odontology cannot be over emphasized, as the tooth, the whole tooth and nothing but the tooth often offers a reliable source of information.

Teeth are the most durable remains of any dead animal. They enable species to be identified and classified hundreds of thousands of years after death. Teeth are fossils, out lasting all other bodily structures. The human dentition by its genotypic and phenotypic variation enables researchers to establish racial and personal identity. Various features of teeth including patterns of abrasion and attrition are used to determine both age and antiquity.

Forensic odontologists use dental sciences to assist the identification of individuals in life and death. The knowledge of forensic odontology is used in criminal and civil matters, as well as in mass disaster situations where both anatomy of the dentition and dental restorative materials may provide sufficient information by which to establish identity.

HISTORICAL PERSPECTIVE

Forensic odontology may have been with us since the beginning of time when according to the Old Testament, Adam was convinced by Eve to put a ‘bite mark’ in an apple.

Interest in forensic dentistry was apparently heightened in the later part of 19th century. The first formal

instructional program in forensic dentistry was given in the United States at the Armed Forces Institute of Pathology. Since then, the number of cases reported has expanded to such an extent that the term 'Forensic Odontology' is familiar not only to the dental professionals but also to the law enforcement agencies and forensic groups. Forensic odontology in the past has played a significant role in identification of unknown body, mutilated corpses and in solving of criminal cases.

Many fascinating cases are reviewed in the historical literature on this subject. The earlier reported case was that of Lollia Paulina in the year 49 A.D. Soon after her marriage in the year 49 A.D. to Claudius, Emperor of Rome, Agrippinna, the first wife of Claudius, sent her soldiers to kill Lollia Paulina because she feared that the rich divorcee Lollia Paulina might still be a rival for her husband's attention. Her dead body was identified, by her teeth, which were known to have certain distinctive characteristics. Only After seeing this was Agrippinna satisfied that it was the body of Lollia Paulina. Later in the year A.D. 66 Nero's mistress Sabina got Nero's wife killed (by her soldiers) and demanded to see the head of his wife on a dish. She recognized the head by the black anterior tooth.

A detailed report on the human bite marks and its classification on human skin was described for the first time in Indian literature, in the "Kamasutra of Vatsayana" (the art of love making) written 17 centuries ago. One of the early reported cases of identification is also found in India.⁶ Raja Chei Chandra Rathor of Cannouj died on the battle field in 1193 and his body was badly mutilated. His false anterior teeth later identified him.

In September 1884- Reid, a dentist, read an important paper of the British Dental Association meeting in Edinburgh about the application of dental science in the

detection of crime. He described the case of a doctor and his mother who were brutally murdered and surrounded by bits of bone and teeth. Reid reconstructed the doctor's jaw but 2 teeth, which were left behind turned out to be that of the village idiot who had murdered them.

In 1897 a paper entitled "The Role of the Dentist in the Identification of Victims of the Catastrophe of the Bazaar de la charite Paris, 4th May, 1897" was presented by Dr. Oscar Amoedo at the International Medical Congress of Moscow. The visual identification of the bodies of those killed in the fire was difficult because they were mutilated and extensively burned. The Paraguayan Consul suggested that the dentist of the missing persons be called to chart the dentition. A year later Dr. Amoedo wrote his thesis on the value of the dentist in medico-legal affairs.

In 1906, two colliers were charged with breaking into the co-operative society's store and stealing some articles of value. During examination of the premises some cheese was found. A piece had been bitten out leaving marks of the teeth. The two colliers were arrested. One of them allowed impressions of his teeth to be taken and the teeth on the models fitted the marks in the cheese. This case was another landmark in forensic dentistry since it was the first recorded instance where expert evidence was given from the "Bite Marks". Later, in the year 1906, Justice of Peace and local government reported that bite mark identification might be developed so as to become of sufficient evidence.

In 1946, Norwegian patriots were stripped of all clothing and possessions before being executed by the enemy. The identification of these bodies, described, how after being executed it was possible to identify them by dental records and remains.

The reconstruction of the soft tissues of the face utilizing information by the remains of long dead people is a subject

that has fascinated many people for many years. One of the earliest examples of this idea being put into practice must be the Neolithic plastered skull excavated at Jericho in 1953.

Description of the teeth of unidentified bridges are often published in dental journals. Such efforts have rarely produced results. However, Commissioner Edward J. Hickey in the year 1970 placed a “wanted information” advertisement in the Journal of American Dental Association. A dentist from Springfield, Massachusetts, saw the notice and recognized a fixed bridge he had constructed for a patient five years before.

The late president of Pakistan General Zia-Ul-Haq died in the year 1988 in a plane crash due to explosion. His body was badly mutilated and unrecognizable. He was identified from his dentition.

In the last few decades, the basic pattern of forensic odontology has changed quite a lot. Advances in dental materials and laboratory techniques, with improvements in scientific and photographic technology, have made the proof of presentation much nearer to forensic sciences.

DEFINITIONS AND TERMS

The spectrum of the forensic sciences, defined as any organized body of scientific knowledge or technology and its subsequent application to forensic matters, ranges from trace evidence analysis, which deals with particulate evidence as retrieved from the scene of a crime or felony, to forensic pathology, which concerns itself with the dead body and its relationship to any subsequent legal situation. Several areas of study included in the forensic sciences are the fields of missile ballistics and tool mark comparison, analysis of questionable documents, fingerprint identification, serologic analysis of body fluids, toxicology,

metallurgy and criminology. Particular areas within the forensic science spectrum, which directly relate to the human subject, include the fields of forensic psychiatry, forensic anthropology and dentistry, and forensic pathology.

Forensic dentistry, which is a branch of forensic medicine, has been defined by Keiser-Nielsen (1970)¹ as that branch of odontology which in the interests of justice, deals with the proper handling and examination of dental evidence and with the proper evaluation and presentation of dental findings. The subject can be divided roughly into three major fields of activity, namely civil or non-criminal, criminal and research.

Civil

The civil classifications will include-

1. Malpractice and all aspects which may eventually lead to criminal charges in the form of fraud.
2. Neglect, where damages may be sought.
3. Identification of individual remains where death is not due to suspicious circumstances – whether fragmentary or complete.
4. Identification of a living person, e.g. with loss of memory.
5. Major mass disasters – the identification of victims of an aircraft or train disaster.

Criminal

1. The identification of persons from their teeth. This section is subdivided into two parts.
 - a. The living person
 - b. The dead person
2. Bite marks –
 - a. On food stuff
 - b. On the assailant

- c. On the victim -
 - i) Self inflicted
 - ii) Inflicted by another

Research

- a. Academic training and courses
- b. Post graduate tuition

Forensic odontology may be defined as the application of dental science to the administration of the law and the furtherance of justice². It involves:

1. The correct handling and examination and the proper preparation and presentation of dental evidence in both civil and criminal legal procedures.
2. Identification of unknown deceased persons
3. Age assessment
4. The investigation of tooth marks or bite marks
5. The comparison and identification of lip prints
6. Legal aspects of dental traumatology

Forensic dentistry refers to the science of dentistry as it relates to the law and has several phases. It may involve (1) claims seeking compensation for dental injury (2) dental malpractice (3) dental fraud and (4) identification by means of the dentition³.

Forensic dentistry, broadly defined as the application of the science of dentistry to the field of law, represents one of many fields, which comprise the forensic sciences. Forensic dentistry is synonymous and interchangeable with the designation forensic odontology.

Forensic dentistry or forensic odontology can best be defined as the science of dentistry as related to the law⁴.

AUTOPSY AND ODONTOLOGY

The dental autopsy is a very important part of the investigative procedure, which ideally will lead to identification.

A forensic odontologist may be required to perform a dental or oral examination on a body in one of the following categories⁵.

Normal: Every thing is normal except that subject is dead. If rigor mortis has partially or fully set in, it complicates the examination by reducing the accessibility. Rigor mortis time frames after death are: -

3-4 hours – commencing

12 hours – complete

18-30 hours – no longer present

Decomposed: The tissues are bloated, discoloured and here is frequently a strong odour. The decomposition can be classified as primary or advanced. If the body or specimen is kept refrigerated, the odour remains minimal. Resected specimens will deodorize if they are soaked in formalin solution for about 30 minutes. They can be rinsed and examined or radiographed.

Mutilated: The bodies in high impact accidents, such as an air crash, would fit into this category, where one finds tissue and bone destruction with fragmentation.

Burned: The tissues, if very severely burned, can sometimes be scraped off the bone to provide easier access to the oral cavity and the teeth. Depending on the degree of burning, care must be taken if using a power saw because the vibration may cause the brittle bone and teeth to disintegrate. If the specimen appears fragile it can be strengthened before sectioning by spraying it with artists clear matte finish. The manufacturer's rules must be observed regarding ventilation when spraying. When the approximate thickness of three ordinary photographic prints is built up, it is quite strong. The material is completely radiolucent, so radiographs are as clear as they would be

without coating. An alternative method is to expose the anterior dentition carefully and, using an etching brush, coat the fire-damaged teeth with cyanoacrylate glue.

Skeletonized: The bones are without soft tissue, or only remnants remain in a few areas. This is the easiest to deal with in regard to accessibility for examination, radiographs, photographs and study model impressions.

APPLICATION OF FORENSIC ODONTOLOGY

1. ODONTOANTHROPOLOGY

A. AGE ESTIMATION AND IDENTIFICATION

Identification of an unknown body or even a living person can be defined as a statement based on certain proven facts, which correspond to those of a specific person⁷.

The use of the teeth as a means of identification of the unknown body is based on the same principle that is common to the other methods of identification, namely the principle of comparison⁸. The fact that fingerprints and the dentition represent rather permanent signatures quite unique for the individual in question is the reason why these physical characteristics stand alone as being the scientifically reliable methods of identification. A reliable method of identification must embody certain criteria to allow valid application to the principle of comparison. These criteria include:

1. A medium which possesses multiple, permanent, measurable or observable points of specificity so that relative individuality of the medium exists.
2. Previous accurate registration of the characteristics of individuality (the ante mortem data) that must be available for comparison with any subsequently retrieved data (the post mortem data) and

3. A medium, complete with its contained features of specificity that must be resistant to destructive forces so that it persists as a pillar of individuality in the absence of other identifying features.

The individuality or specificity of the dentition is based upon the multiple points of comparison inherent in a variable combination of events, which alter the status of a given set of thirty-two teeth, each comprising five anatomic surfaces. Such events include:

1. Hereditary, congenital or developmental alterations
2. Acquired, natural or traumatic alteration
3. The presence or absence in multiple combinations of one, many or most of the thirty two units; and
4. The combinations and permutations in the variable construction, constitution and morphology of a various array of restorative procedures, materials and prosthetic devices employed by the dental profession.

Indeed, a basic premise of dental identification is that no two mouths are identical. Theoretically, this may represent a true statement; however, in actuality the reliability of this statement depends upon the number of points of specificity available for the comparison between the ante mortem and the post mortem data in any particular case.

Certain occupations or personal habits may induce unusual wear or attritional pattern in the dentition. The habitual opening of bobby pins (as in females or male hairdressers) with the anterior teeth may result in a notching of the incisal aspect of the upper central incisors. Carpenters, shoemakers, upholsterers, seamstresses and tailors may similarly develop notching of the central incisors from holding nails or pins. Workers exposed to abrasive dust (e.g. Sand blasters, etc.) may develop more generalized attritional alteration of the dentition. Certain musicians may

develop broad attritional changes of the anterior teeth due to clenching of the instrument mouthpiece. Inveterate pipe smokers (or even cigar smokers with bite stems) also develop broad areas of excessive wear generally located in the lateral incisor, cuspid or premolar regions.

The socioeconomic status of the deceased may be suggested by the nature and the characteristics of the observed dental care. The presence of multiple crowns, bridgework, gold restorations and root canal therapy all bear the connotation of a generally well-educated individual of more than modest income standards. In contrast, the presence of poor oral hygiene, characterized by few restorations, many decayed teeth and signs of periodontitis generally designate an individual of low socioeconomic status. In addition, the finding of many previously extracted teeth without replacement by bridgework or partial dentures also correlates with persons of lower social strata.

The estimation of age can play an important role in the forensic identification of skeletal remains. Anatomical and radiographical investigation of the state of development and fusion of the bones of the skeleton provide one means of age estimation. Similarly the examination of the stage of formation and the progress of age changes in the teeth constitute another source of information. In some cases where advanced decomposition has taken place, or in instances where the remains have been subjected to high temperature, the investigation of the dentition may assume considerable importance. Under these circumstances, due to their resistance to physical damage, the teeth may be the only skeletal evidence remaining in a sufficient undamaged condition to permit useful examination.

Dental age is estimated by comparing the dental development status of a person of unknown age with published dental development surveys. By doing so, a likely

chronological age for that individual can be deduced. This makes a valuable contribution to the identification process. Most authorities are agreed that data derived from the developing dentition provide the most accurate means of age estimation. Dental development data are usually based on:⁹

- Histological premineralization sequences
- Histological mineralization sequences
- Incremental patterns of enamel and dentin formation
- Emergence of teeth into oral cavity
- Gross mineralization sequences observed by-
 - a. Radiographic means and
 - b. Direct observation of dissected developing teeth in situ or individually.

Odontological estimation can be thought of as a triad: the subject for age estimation, the appropriately chosen development survey and the legal considerations – each aspect being itself subject to variation.

It must be emphasized that age determination in the forensic context is not the same as that required in the clinical situation. The findings will have legal consequence, and at best may be challenged by lawyers, or at worst may lead to a miscarriage of justice. There are no guidelines that can be applied to age assessment. The choice of approach is largely governed by experience, familiarity with dental development surveys and the specialist help available. Although dental development surveys are packaged in different ways, they give us two types of information; the sequence of developmental events and the timing at which these events are said to occur.

In young people age determination from examination of teeth is relatively simple and can be made from radiographs or sections through developing teeth. The mineralization of hard dental tissues has also been shown to correlate strongly

with chronological age. After the completion of tooth development, assessment of age accurately becomes increasingly difficult, and is done by using various methods such as measuring the increase in mineral content of teeth, colour changes in teeth and increasing racemisation reaction of aspartic acid. Racemisation may be one of the most accurate methods of age determination and is currently being assessed in both modern and archaeological material.

Since, the advent of restorative dentistry, material used by dentists has created a specific set of characteristics unique to the individual to whom those materials have been applied in the attempt to restore the function, shape and appearance of teeth damaged by defective developmental process, by disease and by trauma. The materials used include polymers, metals and ceramics and their analysis may be used to identify an individual by the arrangements of the cavities or preparations in which they are placed, together with the actual type of material used in the restoration.

Dental science has long been concerned with the repair or replacement of teeth for aesthetic and functional reasons. As technology progresses, altering the nature of restorative materials more refinement and improvement of quality in dental materials, have taken place in the past generation than during any other period of dental history, yet cases where dental materials have been used in individual or group identification processes are reported from ancient times.

In 1772, dental materials provided the basis for identification of the remains of the American General Joseph Warren. His dentist, Paul Revere, recognized a prosthesis he had made for his client in the form of two carved ivory teeth fixed in place with silver thread. This is the earliest recorded case where dental materials played a part in forensic identification of an individual.

The most famous recent case involving dental materials is that of Dennis Nielsen. In 1983, he confessed to about 15 murders. He was unable to name his victims and only fragments of incinerated bone and teeth of some of them remained, largely flat-rolled into the pebbles of the garden path at his Muswell Hill home. Post-mortem radiographs of a wired fractured jaw, which compared precisely with an ante-mortem radiograph, identified one victim. Another was identified by a plastic denture, which fitted to a reconstructed maxilla.

Sociological and cultural determinants affect the distribution of the type of dentistry and the materials used throughout the world. There are significant variations in dental restorations that reveals racial and geographic factors pertaining to both the dentists and the patient. For example, steel and aluminum crowns frequently originate in Eastern Europe, but one has to wonder whether the political changes of recent years bring that sort of dentistry into a new age. Apart from the occasional Caucasian pop star, anterior gold is widely used in Caribbean and Latin American. Gold plated materials are used in the Far East. These are important stepping-stones to be used in, for example, mass disaster investigation¹⁰.

Radiography can play an important part in forensic odontology, mainly to establish identification. This may take the precise form of comparison between ante-mortem and postmortem radiographs. Radiographs may also be taken to determine the age of a minor victim and even help in the assessment of the sex and ethnic group. It is necessary for the forensic odontologist to be familiar with the relevant maxillofacial views as well as the radiographic techniques for the dental arches, both intra-oral and extra-oral. These views establish identification by the comparison of amalgams, crowns and other prostheses as well as

endodontic procedures such as root canal treatment and apicoectomies. Radiography may have to be carried out in the field or at the scene of autopsy, although radiography of the 'as found' specimen in the dentist's own surgery is more common. The two most important principles to remember in this field are firstly, that the object of the exercise is to reproduce the existing ante-mortem radiograph or portion of the radiograph, whether it is good or bad radiograph. Secondly, in so doing, it is essential to be methodical and to document each stage of the procedure, as this may follow a long and tedious path.

Radiographic Appearance of Dental Restorations or Procedures

The following statements apply to the radiographic appearance of dental restorations or procedures.

1. All dental metals (amalgam, gold, fixed bridges, partial denture frame work) are markedly radio-opaque when compared to tooth structure.
2. Silicate and acrylic restorations are radiolucent when compared to tooth structure.
3. Root canal cones are more radio-opaque when contrasted with surrounding tooth structure.

Determination of Sex and Race¹¹

Sexual dimorphism in the dentition is extremely variable. As a rule, female teeth are a bit smaller, most notable the mesio-distal diameter of the permanent molar. However, sexing by teeth alone is risky and not recommended. If there are other skeletal remains that can be sexed, then the teeth should only corroborate rather than diagnose.

Shovel shaped upper central incisors and lateral incisor are found in Mongoloids and lower first permanent molars with a 5 cusp Y shaped groove pattern (Dryopithecus

Y-5) are found more often in Negroids than in Caucasoids. In a study to determine racial differences among Japanese, American Whites and Blacks, Lima Indians and Eskimos, in deciduous teeth dental crown features were grouped as racial and non-racial. The nonracial features found in all races with similar frequencies included well-developed hypocone formation in the 2nd molar and double fold in the canine of the maxillae. The major characteristics in the Caucasoid complex are the high frequency Carabellis cusp and large value (average 106.3) of canine breadth index ($100 \times$ mesiodistal diameter of upper central incisor). In the adult most of these features hold true.

The frequency of well-developed shovel shaped upper central incisors is as high as 8.5 percent in Chinese and is low in Whites and Blacks. In Mongoloids, incisors have shorter roots, are congenitally missing more often and have more occlusal enamel pearl in premolars than other races. Also in Mongoloids, molar roots are frequently fused, less splayed, and shorter, Carrabelli cusp occurring on the mesio/lingual aspect of the first molar is as high as 37% in Whites, few in Bantus and almost absent in Eskimos, Enlargement of pulp cavity with fused roots or taurodontism is rarer in Caucasoids. In Mongoloids when present they may look like an hourglass or pyramidal. In general, the depth of the cavity is the most important aspect in the recognition of the condition.

In the mandible the first permanent molar, often; but not always, is fine cusped with a Y shaped inter-cuspid groove in blacks. A paramolar tubercle or protostylid on the mesio-buccal surface of the molars is found more often in Eskimos and Blacks than in Whites. Tooth crowns are more bulbous and tapering toward the neck in Mongoloids. Enamel extensions are more common and roots are shorter, straighter and less splayed in Caucasoids. In Mongoloids,

there is frequently an extra distolingual root on the first or third molars but rare in others. Mandibular taurodontism is found in all races. But the hourglass and pyramidal types are more frequent in Mongoloids.

The root number does not seem to be race linked nor the congenital absence of third molars. Yet fourth molars are observed in African Kungson and Blacks more than others. Molars decrease in size from the first to the third. But this factor was not found racially different either.

There may be variations intra-racially as well as inter-racially. As in many biological traits, most of the dental features mentioned (above) show a degree of development or gradation such that there is no clear-cut difference between the presence and absence of characteristics.

Dental Genetics and Congenital Conditions¹¹

The most frequently, congenitally missing teeth are the third permanent molars and the upper lateral permanent incisors. No specific side has been described as most frequent. Occasionally, lateral incisor is only partly missing, that is, it is present but is reduced only to a peg shape. It has no incisal margin but is reduced to a pointed or blunted tooth. If a skull is found with a missing upper lateral incisor (not lost ante-mortem or post-mortem), it is a useful genetic criterion. It is inherited in what are termed "family lines". This means that the trait should be looked for in persons possibly related to the unknown represented by the skull and or other skeletal remains. Congenitally, absent third molars are also said to occur with a family line transition. However, such a relationship is, in principle, much too variable to be an absolute familial trait.

The third molar was absent in prehistoric and early historic people 0.69% (Egyptians) and 10.8% (neolithic to medieval times). In more recent populations, it is absent

0.2% (Anglo-saxon) to 32.2% (Chinese). As a general rule, Brotherwell states that the congenital absence of teeth is an evolutionary trend, not specific to *Homo sapiens* but to other animals with 'smaller jaws'.

Missing teeth are genetically classed as follows:

Absence of permanent, lower, central incisor is dominant; absence of permanent upper lateral incisor is given as the dominant recessive or sex linked, absence of permanent premolars is dominant; and absence of permanent third molars is dominant. Hence, congenitally missing teeth in skulls is a possible clue to a related family tie. It must be pointed out that the genetic absence of teeth really cannot be used in a definitive sense. It is possibly corroborative in regard to a suggested relationship made by other skeletal characteristics.

Mass Disaster

On some occasions, the forensic dentist will be faced with an accident such as an air crash, which involves multiple fatalities whose identities need to be established. The underlying principles remain the same; as mentioned in identification procedure, however, some of the rules do change. Forensic dentists will be only part of a team including the police, coroner, medical examiner investigators, and others assigned to analyze the incident. A forensic dental leader will be appointed and he speaks for and receives direction for an entire forensic dental team. In many countries, dental disaster teams have been established and have made plans and stock piled materials to deal with just this type of emergency. Whether or not a team has been established, a division of the tasks associated with dental identification is usually in order. Separate sections for post-mortem dental examination, ante-mortem record assembly, and final comparison should be

established. Several persons will view each dental specimen, minimizing the possibility of incorrect transcription. The radiography of the specimens also must be handled with special care so that no radiographs are mislabeled as to which body they came from. The post-mortem section will interact closely with the forensic pathologists and radiographers.

The ante-mortem section will be responsible for collecting, storing and translating each of the ante-mortem dental records received. Their goal will be to provide a composite record on each of the putative victims. The composite record may be entered on paper or into an electronic database for computer aided comparison. In either case, the incoming data must be translated from a myriad of charting forms, tooth numbering systems, and often languages into a standardized format. The final comparison section is usually the smallest in number of persons, and until sufficient ante and post-mortem records have been assembled, can be assigned elsewhere. The final determination of identity through dental means, however, rests with this section. One individual should be named the leader and be the only individual authorized to release dental results to any agency investigating the crash. This group will in many cases use a computer-assisted model such as computer assisted post-mortem identification system (CAPMI) to make the initial sort of ante and post-mortem dental records. Even so, the group must itself analyze the computer suggested records and decide if the identity is positive, possible, excluded, or if insufficient evidence exists. If computers are not available, the group must devise some method of comparison to allow for elimination of unlikely candidates. Matrix systems, tickler files and old-fashioned item-by-item comparison have all been used successfully in the past.

A major disaster may be loosely defined as a disaster involving about twice as many as the local mortuary is capable of catering for whilst a mass disaster is one where there are 300-400 more⁷. The most common type of this disaster is an aircraft accident.

Muhelmann H R et al (1979)¹³ reported a system for identification of mass disaster victims, the Swiss Identification System that eliminates the necessity for locating ante-mortem dental records, avoids the delay involved in post-mortem X-ray examination, and does so by placing a pin and restoration in the dentine.

Wood Ward J (1979)¹⁴ described a method for including the patient's name in the denture base material for identification purposes, an identification strip with patients name can easily be incorporated into dentures during the packing procedures. The author concluded that the procedure is simple, takes little time has almost no cost and is effective.

Bite Marks Analysis (Patterned Injuries)

From the onset of human hostility man has used his teeth as a weapon to bite his victims. Teeth have also been used as means of defense. It has long been recognized that bite marks are unique and can be attributed to specific individuals.

A bite mark is defined as the mark created by teeth either alone or in combination with other oral structure.

A bite mark may be defined as a pattern produced by human or animal dentitions and associated structures in any substance capable of being marked by those means⁹. It is more commonly associated with marks in the skin, but is also of forensic odontological importance in foods and other inanimate objects.

Bite marks may be present following a fight between adults or children as part of the sexual or physical assault

by an adult on a child. In rape or attempted rape, bites are likely to be noted on the breasts. The marks, single or multiple in nature, may be of varying degrees of severity ranging from a mild marking of the tissues to deep perforation of the epidermis and dermis and may be found (in order of frequency) on the breasts, face/head, abdomen, shoulder, upper extremity, buttocks, female genitalia, male genitalia, legs, ear, nose and neck. An American study noted that the arms were the most frequent sites, followed by breasts, legs, abdomen, back, face/head, shoulder, buttocks, female genitalia, hand/finger, chest, neck, nose, male genitalia, ear and foot.

When called to examine suspected bite marks it is first necessary to ascertain whether the mark could have been caused by teeth. Bite mark examination is the one aspect of forensic odontology requiring an immediate response by the forensic odontologist. The marks fade rapidly both in the living and the dead, changing appearance in a matter of hours. Delay in examination may result in loss of valuable evidence. The forensic odontologist is also responsible for the examination of the dentition of those suspected.

The concept of comparing the mark made by the dentition of an individual in the skin of another individual has been well accepted by forensic odontologists. The use of this 'novel' type of evidence in the criminal justice system with the resultant publicity has caused a heightened awareness of the need for recognition, collection, preservation and comparisons of bite marks.

It is fundamental to the entire investigation of a suspected bite mark to treat it as such until proven otherwise. Clearly, unless each and every element in the injury pattern is carefully evaluated, a valid opinion cannot be given. The non-expert using his dental training and experience,

together with common sense, should be able to successfully consider the factors involved and make decisions, which have some validity.

Bite marks may be found on living or dead persons. The person may be the victim of the crime or the perpetrator of the crime.

A forensic odontologist needs to be able to recognize and positively identify human teeth. In addition, the odontologist should be able to recognize a non-human tooth and be able to say, at the very least, if it originated from a carnivorous, herbivorous or omnivorous mammal; the more informed odontologist will be able to classify the animal.

(Details of recording bite marks are described later)

Archeology

The methods used in odontoanthropology described earlier are used in anthropological and paleontological investigation to determine age, sex, race etc. They can also give evidence regarding relationship of the individual to the environment, eating habits and cultural modifications in the era of their existence. Taphonomy is the study of the process by which animal or plant remains become fossilized. Geotaphonomy is the study of geophysical characteristics, and changes in, subterranean features associated with the internment of buried evidence. This analysis uses archeological field techniques for the recovery and interpretation of phenomena introduced during construction of a grave or other burial features.

Dental Application DNA

DNA analysis has significantly helped in identification processes. As the general population DNA data banks are not available readily it may be a problem to compare a specimen with pre-existing data. However, it holds great

potential for the future. At present nuclear or mitochondrial DNA profiling analysis is used to re associate fragmentary remains in mass disasters etc. This is based on identifying similar DNA profile patterns.

The current DNA profiling or fingerprinting techniques are:

1. Restriction Fragment Length Polymorphism (RFLP) on variable number tandem repeats (VNTRs). RFLPs analyze highly variable regions of DNA.
2. Polymerase Chain Reaction (PCR). It amplifies a specific DNA region.

Schwartz et al, reported a study of DNA obtained from teeth subjected to a variety of environmental conditions. The studies were on the dental pulp using restriction enzyme digestion and RFLP on loci DZS44, DXYS14, D18S27 and DXZ1.

Smith et al. 1993 also reported a systematic approach to sampling dental DNA for identification. He used crushed specimens of tooth specimens. Teeth from the same individual were separated from other teeth specimens. When DNA is highly degraded the mitochondrial DNA can be used. The importance of obtaining DNA from the tooth is because the teeth may be the only tissue that survives a fire or high temperature. The calcified structures may insulate and preserve the pulp, which can be used for DNA finger printing.

Child Abuse

Rights of children have never been adequately recognized or addressed in India. Most instances of child abuse go unnoticed or unreported. The fact remains that there is a frightening rate of child abuse in India. Forensic science has a significant role to play in identification of child abuse. Injuries to children are never scrutinized with an eye on the

possibility of abuse by parents, relatives, teachers or acquaintances.

Child abuse may be defined as any act of commission or omission that endangers or impairs a child's physical or emotional health and development. Such acts include physical, emotional or sexual abuse.

The forensic odontologists and for that matter all dentists have an opportunity to detect these instances and a legal obligation to report them. The orofacial region is often involved in child abuse as crying or speaking emanates from the mouth and therefore ends up being the focus of the violence. Studies have shown that the orofacial region is involved in 50% of child abuse victims.

The dentist has to be critical and watchful while taking a history of a child with orofacial injuries. General examination of such children usually shows malnutrition and multiple injuries in various stages of healing, indicating repeated trauma. Child abuse particularly those with a sexual overlay show the presence of bite marks, which should be recorded and investigated. Other common injuries are tears of labial or lingual frenums, oral mucosal tears, fractured or avulsed teeth, trauma to lip and fractures of the jaw. These children often have neglected mouths with rampant caries and poor oral hygiene.

However, it must be cautioned that over enthusiasm and over diagnosis is also a potential problem, which may cause harm to innocent parents and children.

FORENSIC DENTISTRY-METHODOLOGY

DENTAL IDENTIFICATION PROCEDURE

The first step in a dental identification is to gather all of the dental evidence associated with the unknown body.¹² A visual examination of the entire body usually will help to establish the gender, race, and approximate age of the

victim. Double check and record the identifying marks or numbers assigned to the case by the coroner or medical examiner's office. Record any pertinent facts about the case furnished to you by the authorities. If it is the possibility of accompanying law enforcement personnel to the scene where the body was discovered because the non-dentists examining the crime scene can easily overlook dental evidence. Carefully retrieve and label any additional dental evidence uncovered. Gloves and other infection control procedures must be followed when handling human remains. Remember to thoroughly search the body bag and wrappings or clothing present with the body for any teeth or dental appliances that may have become dislodged during transport and handling of the body.

A thorough, systematic search of the oral cavity and supporting structures is next. The condition of the body usually will dictate how this is accomplished. If the body has decomposed, has been badly burned, or is skeletonized, adequate visualization of the dental structures may require some soft tissue dissection. Bilateral facial incisions are used most commonly. In most jurisdictions, the coroner or medical examiner has the legal authority to request that the odontologist perform the necessary dissections. However, because laws dealing with death investigation and mutilation of corpses vary, the prudent dentist should be familiar with the law of his or her jurisdiction and obtain the proper authorization prior to any dissection. If the body has not decomposed and may yet be viewed by the next of kin or others either as part of an ongoing attempt at identification or at burial services, the odontologist would be ill-advised to use any procedures that would leave visible marks on the face, even if authorized to do so. There are dissection and reconstruction techniques available that allow virtually undetectable removal of the jaws from an

inframandibular approach. Rigor mortis can impede access to the oral cavity. The dentist can elect to wait until rigor subsides (upto 48 hours after death); can attempt to break the rigor by carefully and slowly applying downward opening pressure on the external oblique ridges of the mandible (injury can result if slippage occurs); or, if a sufficient opening can be obtained inter-incisally, the muscles of mastication can be incised intra-orally.

Although excellent exposure of the facial surfaces of the teeth can be obtained with soft tissue dissection in the burned body, the extreme contracture of the muscles of mastication will not lessen with time. The application of force may irreparably damage the remaining dental evidence. In these cases, or in the case of a non-viewable body for which dissection authorization has been obtained, a vibrating saw can be used to amputate the mandible at the level of the occlusal plane to facilitate opening the jaws. If the odontologist wishes to retain the jaws for future reference or use, the maxilla can also be detached using the vibrating saw or a bone chisel just inferior to the zygoma and the anterior nasal spine. If the specimen is badly charred, either of these techniques can cause further breakdown. Therefore, great care should be exercised and some forensic dentists suggest the application of cyanoacrylate or other physical fixative to the teeth before proceeding; however, this can cause problems later on as it may prevent any further cleaning or separation of the teeth. In both maxillary and mandibular resections, one must be careful to direct all cuts so as to spare the roots of teeth and to allow any unerupted teeth (such as third molars) to be included in the resected specimen. Some soft tissue dissection will be required to complete the resection. Some jurisdictions require additional legal authorizations to retain autopsy material rather than return it to the body for burial.

Once access to the oral cavity has been established, the teeth are cleaned if necessary and a comprehensive examination of the mouth is started. This examination is very similar to the one done for the living patient. A carefully executed postmortem charting of all teeth present must be done. The chart should note the number of teeth present and to as great an extent possible, why missing teeth are absent. Particular attention must be paid to the sockets of missing teeth that were present at death but were lost subsequently – postmortem loss; those that may have been lost hours or days prior to death-premortem loss. In the presence of decomposition, it is quite common for singly rooted teeth to be lost postmortem. The sockets of those teeth will have sharp margins and usually will be without associated fractures. A diagnosis of perimortem or premortem loss may have to be reinforced by histologic examination of the soft tissue to confirm the presence of vital reaction to injury or the initiation of a healing response.

The next most important dental characteristic is the condition of each individual remaining tooth. The restorative pattern is highly unique to each individual. Document, the surfaces, the morphology, and the dental materials employed to restore caries. Adequate lighting, a front surface dental mirror, a sharp explorer, and clean teeth are as important here as in the clinic. Pay particular attention to the possibility that tooth colored restorative materials may have been employed, as these can be quite difficult to detect. Transillumination, radiographs, and various staining agents may be of help. Failure to discover a restoration may result in the elimination of the correct ante-mortem record from consideration due to a false finding of an inexplicable discrepancy. Also note the manner in which any missing teeth have been replaced prosthetically. Complete or partial dentures may have the name or some identifying number engraved or otherwise

manufactured into them. If alveolar implants are present, document the number, position, and type of attachment to the prosthesis associated with them. Record any areas of caries and any other defects, anomalies, or oddities present on any tooth. Record any areas of abrasion or attrition or other usual wear patterns. Chart the degree and direction of any inclination or rotation present in any tooth. Pay particular attention to the first molar area in adults because these may have been extracted and posterior teeth may have drifted forward.

Observe the mouth for any gross signs of pathology, tori or exostoses, gingival or periodontal disease, or recession. Attempt to ascertain the occlusal pattern of the dentition as well as any oral habits that may have influenced the occlusion such as habitual tongue thrust or lip incontinence. Angle's classification and the amount of overbite and overjet should be recorded.

At this point radiographs, photographs and impressions can be made of the dental remains. In the resected specimen these are all quite simple. Remember to label adequately each record and to include a reference scale in the photograph. Radiography of the non-resected jaws can be a challenge. The tube head of a mobile dental X-ray machine may be able to reach within only a few feet of the oral cavity because the body will be recumbent on the pathology gurney or table. If the only type of X-ray machine available is medical, approaching the oral cavity will be even more difficult. Because the anode-to-film distances may be increased greatly, lengthened exposure times may be required as compensation. Radiation safety should be practiced for all personnel in the morgue area. Trial and error may be necessary to initially calibrate the X-ray machine and film to the distances involved. On-site development or self-developing film is recommended so that

the results can be viewed quickly and any retakes can be made while the body is still easily available. In most cases, the odontologist will attempt to duplicate the exposure of ante-mortem films; therefore bite-wing and periapical exposures should be made. Although wax or modeling clay can be used to position the film in the mouth, a handful of wadded-up paper towels can be packed between the film and the tongue to immobilize the film. The jaws can be held shut for bite-wing projections by using a piece of cloth as a chin strap bandage or by using instruments such as tongue depressors braced between the chin and the neck or chest. If third molars are not visible in posterior quadrants, the odontologist should obtain a radiographic exposure in each area. If fragmentary or otherwise resected dental remains are radiographed, it is very important to orient each specimen properly on the film plate relative to buccal and lingual projection. Be absolutely certain that the lingual surface of the specimen contacts the film as if the radiograph were being exposed in the mouth. In the charred body, incisions can be made under the mandible into the floor of the mouth to allow the insertion of X-ray film into the mouth without damaging the fragile, fire-damaged oral structures. All films should be mounted and labeled as soon as possible to prevent loss or misfiling.

Resected jaws should be photographed on the countertop in proper anatomic relation and from several other angles, including occlusal views. Photography, mirrors and retractors will be required, as will the services of a photographic assistant to stabilize the oral tissues. A tripod-mounted camera also will aid in the production of high-quality photographs. Although police or morgue photographs of the dentition may be available, an odontologist, properly equipped and trained in oral photography, can record valuable dental evidence that otherwise might be lost.

Photographs may have to be presented in a court of law, or they may be the primary evidence the odontologist relies on many years later to solve a long dormant case.

A label with case identification information should be included in the field of every photograph and it is good practice to begin each roll by shooting a frame or two of a business card to protect against loss or mix-up of the negative roll during processing. Black and white as well as color photographs should be exposed. The views should include a head and shoulders view, an extra-oral close-up, the teeth in occlusion from the anterior as well as from right and left buccal perspectives, and maxillary and mandibular occlusal mirror views. Electronic flash is the preferred means of illumination, using either a point or ring light. When photographing partially skeletonized remains with a non-automatic exposure control flash, one should bracket the exposures because the bone will not absorb as much light as will soft tissue, making overexposure likely. One simply cannot take too many photographs.

Impressions of resected jaws that remain in the custody of the odontologist are probably unnecessary. However, unless a resected specimen is badly charred, the procedure is simple. In cases of badly charred remains, whether resected or not, impressions probably are not warranted because the impression material may destroy the dental evidence and a poor replica is likely to result in any event. If the dentition is to remain in situ, certain techniques must be observed when obtaining models. The teeth and surrounding tissues must be as dry as possible and fluid leakage into the mouth must be prevented while the impression material sets. Although disposable trays are preferred, they must be rigid and an adhesive should be used to ensure a tight bond between the carrier and the material. The occlusal surfaces of the teeth are probably the

most important feature in forensic dental models, but the odontologist must attempt to record every possible dental feature. The rugae of the palate have proved to be quite important in some cases. If the body is edentulous, models may well represent the only useful physical evidence obtained from the mouth.

As stated earlier, successful dental identification depends on the existence of a putative identity. Although law enforcement officials often provide this putative identity, the forensic dentist may often be able to provide valuable clues to assist in the search for ante-mortem dental records. Relatives of the deceased may be able to name the dental practice where treatment was received. One should not overlook dental care rendered while in the military, as these records can be quite comprehensive. In addition, treatment performed by specialists such as oral surgeons, orthodontists, endodontists and periodontists should not be overlooked. Their records of treatment may contain valuable information. Most dental practitioners are quite helpful when asked by law enforcement or forensic dentists to surrender their records for use in a dental identification. Dental officers, however, are not the only source of oral ante-mortem records. Hospital radiographs often reveal much information about the jaws and teeth. Many chiropractic offices also radiograph patients on a routine basis and the films often contain a significant amount of dental information. Family photographs also can be helpful in verifying the morphology and alignment of the anterior teeth in some cases. If there is a dental school in the area, the putative name should be checked against their patient list also. In every case in which ante-mortem dental records are found, the forensic dentist should attempt to view the original records and films, not duplicates. The loss of detail and resolution inherent in the duplicating process may obscure just the item that would clinch the case.

Once the complete post-mortem and ante-mortem dental record has been assembled, the comparison can begin. It is vitally important that the forensic dentist understand thoroughly the treatment that the ante-mortem record alleges to present in the mouth. To establish the identity, the treatment present in the dental remains must match that of the ante-mortem record without any inexplicable discrepancies. The number and position of remaining teeth must match; the number, placement, and material selection of any restorations must match; and the size, shape and contour of the teeth must be the same. In addition, the morphology of the root, pulp chamber, and root canal as well as any pathology present in these structures should be compared. When possible, other anatomic landmarks of both the hard and soft tissues also should be compared. If ante-mortem and post-mortem radiographs are available, a side-by side comparison on a view box is the simplest method. If either set of radiographs is not available, then the dental charts or available radiographs must be compared. It is also possible to estimate the age of an individual less than 18 years old with excellent accuracy using dental findings. Knowledge of the times of eruption and shedding of teeth with the state of apical root closure is essential for such a determination.

An inexplicable or irreconcilable discrepancy is one that could not physically occur in nature if the identity were true. The simplest example would be the documented extraction of a tooth sometime before death occurred yet the body in question has that tooth present. Another common example would be when a restoration is visible on an ante-mortem radiograph and the same tooth in the body has no restoration on that surface of the tooth. Such findings would exclude the identity. The reverse is not true. However, it is quite possible (depending on the date of the ante-mortem

record) that an individual could have had a tooth extracted or restored and records of that treatment were not obtained. A reconcilable discrepancy also might include a reasonable assumption that a prior treating dentist has mischarted a tooth or a restoration.

The comparison can yield only one of four possible results. A positive identification occurs when the ante-mortem and post-mortem data match in sufficient detail to establish that they could only be from one and the same individual. There can be no irreconcilable discrepancies in this case. There is no established number of points that must match. If one is using radiographs or models, a single tooth may have literally hundreds of points of coincidence in the morphology of a restoration.

A single unusual dental or restorative feature may be so unique that it stands alone. A possible identification occurs when the ante-mortem and post-mortem dental data have consistent features, but, due to the quality of either the post-mortem remains or the ante-mortem dental evidence, a positive identity cannot be established. The discovery of additional evidence may warrant a change in this opinion. A finding of insufficient evidence results when a basis for conclusion cannot be reached. Finally, exclusion of identification results when ante-mortem and post-mortem data are inconsistent. Such a finding is equally as important as positive identification. The forensic dentist must form his or her conclusions and be prepared to defend them under oath if necessary. Remember too that this opinion is based on the representation that the ante-mortem records relied on was correct as to names, dates, and the like.

BITE MARK ANALYSIS PROCEDURE

The study of patterned injuries is complex. A brief overview, however, describes the importance of forensic dentists called on to examine and give an opinion on bite marks. Bite mark

injuries are a form of patterned injury, that is a wound, which by its configuration suggests that it was caused by a particular object. The first role of the forensic dentist when called upon to examine a suspected bite mark is recognition. Initially, this may entail determining whether the injury was caused by animal or human agents. There are certain class characteristics that should be present to help make that determination. The size, shape and arrangement of teeth in the anterior portion of the arch are represented in the bite. Human incisor teeth have a rectangular cross section at the incisal edge whereas human cuspids are most often triangular in cross section in the incisal portion. Animal bites, especially ones inflicted by dogs and cats, are more likely to puncture the skin and the cross-sectional size of the individual teeth is often quite small and tends toward the circular. The number of incisor teeth may be greater with animal bites and the distance between individual teeth is often greater than mesial-distal width of the teeth.

The size of the dental arch is reflected in the patterned injury. Adult arches vary in width from canine to canine from approximately 2.5 to 4 cm, whereas children's arches are proportionately smaller. Most dog and cat arches are smaller still. In most well documented human bite mark cases, a maximum of the six anterior teeth in each arch make the mark. If both arches mark, then the pattern is usually ovoid or round in shape. The distance between the midpoint of the maxillary mark and the mandibular mark can vary quite widely, depending on the elasticity of the skin bitten and the degree of inter arch opening achieved by the biter in the course of inflicting the wound. Many bite marks also demonstrate a central area of ecchymosis. This phenomenon was once thought to be associated with sucking forces applied while biting; however, this is now

thought to be due to the injury of blood vessels compressed between the jaws of the biter.

Bite marks can be found on the skin of both victims and attackers in crime. The most frequently reported locations in female victims of sexual assaults are the breasts, thighs, anterior shoulder, pubic area, neck, arms, and buttocks. Male sexual assault victims report bite marks on the abdomen, chest and arm. The attacker also may receive bite injuries that commonly occur on the arms, hands and penis.

Certain steps must be taken to document and preserve the bite mark evidence because in deceased individuals the skin and its injury will decompose and in living victims the healing process can obscure the image.

GUIDELINES FOR BITE MARK ANALYSIS

These guidelines are the result of a collective effort of the participants of the bitemark workshop of the American Board of Forensic Odontology assembled in Anaheim, CA, Feb. 18-20, 1984.¹⁵ These guidelines are considered dynamic, not static and will be modified as significant developments evolve. Careful use of these guidelines in any bite mark analysis will enhance the quality of the investigation and conclusion.

The collection of evidence falls into several categories.

1. Description of bite marks.
2. Collection of evidence from victim.
3. Collection of evidence from suspect.

This is followed by analysis of the evidence.

1. Description of Bite Marks

Both in the case of a living victim or deceased individual, the odontologist should determine to record certain vital information.

- A. Demographics
 - 1. Name of victim
 - 2. Case Number
 - 3. Date of examination
 - 4. Referring agency
 - 5. Person to contact
 - 6. Age of victim
 - 7. Race of victim
 - 8. Sex of victim
 - 9. Name of examiner(s)
- B. Location of bite mark
 - 1. Describe anatomical location
 - 2. Describe surface contour: flat, curved or irregular
 - 3. Describe tissue characteristics
 - a. Underlying structure: bone, cartilage, muscle, fat
 - b. Skin: relatively fixed or mobile
- C. Shape: The shape of the bite mark should be described; for example essentially round, ovoid, crescent or irregular.
- D. Color: The color should be noted, for example, red, purple, etc.
- E. Size: Vertical and horizontal dimensions of the bite marks should be noted, preferably in the metric system.
- F. Type of injury
 - 1. Petechial hemorrhage
 - 2. Contusion (ecchymosis)
 - 3. Abrasion
 - 4. Laceration
 - 5. Incision
 - 6. Avulsion
 - 7. Artifact.

It should also be noted whether the skin surface is indented for smooth.

At some point the odontologist will evaluate the evidence to determine such things as position of maxillary and mandibular arches, location and position of individual teeth, or intradental characteristics. This may or may not be possible at the time of initial examination and will be covered below:

2. Collection of Evidence from Victim

It is assumed that evidence gathering from bite mark victims will be done with authorization from the appropriate authorities.

It should first be determined whether the bite mark has been affected by washing, contamination, lividity, embalming, decomposition or change of position.

Photography

A variety of types of photographic equipment and films may be used as described below. While it is recognized that the odontologist is often required to work with evidence provided by other sources that is less than ideal, whenever possible he should obtain or produce photographs which meet the following guidelines.

1. Orientation and close-up photographs should be taken.
2. Photographic resolution should be of high quality.
3. If colour film is used, accuracy of colour balance should be assured.
4. Photographs of the mark should be taken with and without a scale in place.
5. When the scale is used, it should be on the same plane and adjacent to the bite mark. It presently appears desirable to include a circular reference in addition to a linear scale.
6. The most critical photographs should be taken in a manner that will eliminate distortion.

7. In the case of a living victim, it may be beneficial to obtain serial photographs of the bite mark.

Salivary Swabbing

Whenever possible, salivary trace evidence should be collected according to recommendations of the testing laboratory.

Impressions

1. Impressions should be taken of the surface of the bite mark. Whenever it appears that this may provide useful information.
2. The impression materials used should meet standard specifications and should be identified by name in the report.
3. Suitable support should be provided for the impression material to accurately reproduce body contour.
4. The material used to produce the cast should accurately represent the area of impression and should be prepared according to the manufacturer's instructions.

Tissue Samples

Tissue specimens of the bite mark should be retained whenever it appears; this may provide useful information.

3. Collection of Evidence from Suspect

Before collecting evidence from the suspect, the odontologist should ascertain that the necessary search warrant, court order, or legal consent has been obtained, and should make a copy of this document part of his records. The court document or consent should be adequate to permit collection of the evidence listed below.

- A. Obtain history of any dental treatment subsequent to or in proximity to the date of bite mark.

- B. *Photography*: Whenever possible, good quality extraoral photographs should be taken, both full face and profile. Intraoral photographs preferably would include frontal views two lateral views, occlusal view of each arch, and any additional photographs that may provide useful information. It is also useful to photograph the maximum interincisal opening with a scale in place. If inanimate materials, such as food stuffs, are used for test bites, the results should be preserved photographically.
- C. *Extraoral Examination*: The extraoral examination should include observation and recording of significant soft and hard tissue factors that may influence biting dynamics, such as temporomandibular joint status, facial asymmetry, muscle tone, and balance. Measurement of maximal opening of the mouth should be taken, noting any deviations in opening or closing, as well as any significant occlusal disharmonies.

The presence of facial scars or evidence of surgery should be noted as well as the presence of facial hair.

D. *Intraoral Examination*

1. In cases in which saliva evidence has been taken from the victim, saliva evidence should also be taken from the suspect in accordance with the specifications of the testing laboratory.
2. The tongue should be examined in reference to size and function. Any abnormality such as ankyloglossia should be noted.
3. The periodontal condition should be observed with particular reference to mobility and areas of inflammation or hypertrophy. Also, if anterior teeth are missing or badly broken down it should be determined how long these conditions have existed.
4. It is recommended that, when feasible, a dental chart of the suspect's teeth is prepared, in order to encourage thorough study of the dentition.

- E. *Impressions*: Whenever feasible, at least two impressions should be taken of each arch, using materials that meet appropriate standard specifications and are prepared according to the manufacturer's recommendations, using accepted dental impression techniques. The interocclusal relationship should be recorded.
- F. Whenever feasible, sample bites should be made into an appropriate material simulating the type of bite under study.
- G. *Study casts*: Master casts should be prepared using type IV stone prepared according to manufacturer's specifications using accepted duplication procedures. Labeling should make it clear which master cast was utilized to produce a duplicate. The teeth and adjacent soft tissue areas of the master casts should not be altered by carving, trimming, marking or other alterations.

Evaluation of Evidence

Many methods have been used to study bite mark information and as part of the analysis, it is suggested that the findings be evaluated in accordance with an accepted system.

Serological Parameters

Forensic serology has been applied to odontological investigations with reasonable success. Pulps yield tissue for ABO blood groups and serum proteins. In 1993 Lopez-Abadia et al reported a simple technique of for phenotyping alpha-2-HS glycoprotein in serum, blood streams and dental pulp using isoelectric focusing electrophoresis on neuramidase treated specimens.

Typical serological studies of saliva are usually limited to detection of amylase, ABH and Lewis antigens and

several polymorphic markers (based on parotid glycoproteins). Gm and Km proteins have been used for racial determinations.

However, DNA studies have largely replaced serological studies in recent times.

COMPUTERS IN FORENSIC ODONTOLOGY

The use of dental records in forensic sciences is one of the accepted and time-honored methods of identification. A trained forensic odontologist is consulted when identification cannot be determined through visualization fingerprints, personal effects or other methods. Traditionally, the forensic odontologist studies the dentition, using charts, X-rays, photographs and sometimes study models. He then compares his findings with records believed to be those of the subjects in question to confirm or rule out positive identification.

The above method is satisfactory as long as the records presented to the odontologist lead to a positive identification of cases and the subject remains unidentified. The circularization of dental records is almost always futile. Such circularized records will not trigger the recall of a specific dentition by a practicing dentist, unless the dental conditions are extraordinarily unusual. The most practical method by which masses of data can be compared is through the use of computers.

RELIABILITY OF FORENSIC ODONTOLOGY AS EVIDENCE IN MEDICO-LEGAL CASES

Admissibility of new scientific evidence in trials are usually questioned for reliability. Finger printing and bite marks are established evidence even in Indian courts. For that matter even DNA profiles and finger printing. Numerous new techniques and practices have to await scrutiny and acceptability.

The Frye Test is an acceptable test to establish reliability. It emanated from the leading case of *Frye Vs United States* almost 8 decades ago.

There is usually a lag period of appraisal before acceptance of a new technique. The courts have to be careful and skeptical of new techniques as it can result in miscarriage of justice. Prof Gianelli stress the need to “prevent the admission of unreliable scientific evidence”.

FORENSIC PHOTOGRAPHY

It is very important that photographic evidence must be clear and unambiguous. The technical details of forensic photography are beyond the scope of this chapter. However, some broad details can be indicated.

Photographers should adopt a ‘standard’ technique which includes orientation photographs showing where the injury on the body is before taking close-up pictures.

Photographers should take photographs with scale to clearly demonstrate dimensions. Many types of scales are available.

Many photographs from different angles will have to be exposed.

Photographs may be taken with:

1. Visible light photography. This is the most common type and can be taken with most ordinary cameras. It might be in colour or black and white. Both have advantages in specific situations.
2. Alternate light images and fluorescent techniques. Bruises and other pattern injuries like bite marks are better visualized with fluorescent lighting.
3. Nonvisible light photography.

These include UV light sources and infrared light sources. These often enhance and show greater clarity of the area.

Photography is vital in recording accurately, clearly and realistically the evidence to be produced in court. A detailed account is available in professional photography books.

CONCLUSION

It is true that forensic odontology is a very small speciality within the forensic science; though it is by no means a 'new science'. History proves the existence of this science many generations ago. It is indeed a very happy sign that the number of dental surgeons engaged in forensic stomatology and research after the last war is steadily increasing in many countries over the world, including Thailand, Singapore and Hongkong. But unfortunately, it has yet to find a place of its own in India. The main reason for this unfortunate lapse is ignorance on the part of law enforcing authority, the forensic pathologist and the government. Here in our country, unidentified bodies are investigated by local police, and then brought to a forensic pathologist or if skeltonised to an anthropologist or even to an archaeologist. Even in big cities, 'scene of crime' team comprises the local police and the forensic pathologist and it is they who have the priority to examine a body. The maximum use of dental evidence is totally dependent on the investigative police officers. A forensic odontologist cannot make his studies on experimental dental evidence. He can gain his most essential experience and practical training through practical cases only. The investigative police officers must be aware of the nature and role of forensic dental science. The combined effort of the professional police investigator and the odontologist prior to the discovery of unidentified remains allows for an efficient, accurate identification procedure. The importance of forensic odontology cannot be over emphasized. It is high

time that due attention is paid to the application and development of this science in India.

It is important to recognize that social, culture and legal factors will vary the needs for forensic odontology from country to country. It is thus quite inappropriate to impose on a country, a system that may have been successfully developed in another country. Rather, the needs and cultural backgrounds of the population concerned must be carefully considered and modified according to the best interest of the community.

Dental history is one thing that is very difficult to re-write. However, changing technology can give a strong indication of the time and place where dental events happened, which may be important factors in determining identity. People change clothes with one another, steal passports, and have jewellery planted on them but they do not swap teeth, and their teeth say who they are.

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Chapter 17

Taxation Law for the Dentist

INTRODUCTION

Dentists like all professionals are subject to tax on their income. Doctors and other health professionals are generally diffident about dealing with tax and other financial issues. It is important that they have a working knowledge of tax systems that will help them to avoid conflict with the system.

Tax issues relating to commercial tax, sales tax etc, are not addressed in this chapter. Dentists who deal with commercial issues are directed to good books on the matter.

Similarly, detailed tax planning has not been dealt with as it is beyond the scope of this book. There are numerous books for professionals interested in good investment schemes and tax plans.

INCOME TAX

Under the Income Tax Act, 1961, every person whose total income in a financial year exceeds a specified limit is liable to pay income tax at the rates specified every year in the Finance Act.

At present the exemption limit of income is as under:
Individuals, Hindu Undivided Families (HUFs)—Rs.50000
Partnership Firms and Companies—Nil.

Total Income—How Computed

The basis of levy of income tax is the total income of a person.

The total income is classified under the following heads of income:

The aggregate of the income so computed under each head will be the gross total income, from which certain eligible deductions are reduced to arrive at the total income, which is referred to as taxable income.

The rates of income tax applicable to each year is prescribed in the Finance Act.

Individuals, HUFs

Partnership Firms, Companies	35%
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Surcharge

In addition to the above surcharge at the rate of 5% of the above tax is also payable.

Assessment Year

Income tax is charged on the total income of a person for any assessment year at the prescribed rates. An assessment year is the period of 12 months from 1st April every year. Such tax is charged on the Total Income relating to a “previous year”-which is the financial year immediately preceding the assessment year.

For example, for the assessment year 2003-04, the relevant previous year is 1st April 2002 to 31st March 2003.

Person

The expression “Person” has been defined to include-

- a. An individual
- b. A Hindu undivided family (HUF)
- c. A Company
- d. A firm
- e. An association of persons or body of individuals whether incorporated or not
- f. A local authority
- g. Every artificial juridical person, not falling within any of the preceding sub-clauses.

The expression “income” has been defined in section 2(24) of the Income Tax Act. It is only an inclusive definition, which lists out certain items of receipts, which are treated as income for the purpose of levy of tax under the Act. Being an inclusive definition, any item of receipt if received by a person not included in the above said list would **not** necessarily mean that it is not liable for tax.

Residential Status

Under the Income Tax Act, the scope of total income liable for tax depends on the residential status of each person.

Persons have been classified into three different categories based on the residential status viz.,

- a. Resident
- b. Resident but not ordinarily resident and
- c. Non-Resident.

RESIDENT

An individual is said to be resident in India in any previous year if he fulfills **any one** of the following basic conditions:

- I. He is in India in that year for a period or periods amounting in all to 182 days or more;
- II. He is in India for period or periods amounting in all to 60 days or more during the previous year and 365 days or more during the 4 years preceding the previous year.

NON-RESIDENT

If an individual does not satisfy **at least one** of the basic conditions he shall be considered as non-resident.

RESIDENT AND ORDINARILY RESIDENT

In addition to fulfilling one of the above basic conditions, the individual shall have to fulfill both the following additional conditions for him to be considered as resident and ordinarily resident.

1. He has been resident in India in at least 9 out of 10 years preceding the relevant previous year; and
2. He has been in India for a period of 730 days or more during 7 years preceding the relevant previous year.

Once, the residential status of a person is determined in accordance with the conditions prescribed above, the income chargeable to tax as part of total income shall be identified as under:

<i>Particulars</i>	<i>Resident</i>	<i>Resident but not ordinarily resident</i>	<i>Non-Resident</i>
1. Indian income from outside India	Taxable	Taxable	Taxable
2. Income from			
a. Business controlled in India or profession set up in India	Taxable	Not taxable	Not taxable
b. Any other source	Taxable	Taxable	Not taxable

Profits and Gains of Business or Profession

The professional income of a medical practitioner is to be included under this head of income. In computing the income under this head the following expenses are allowed to be deducted under section 36.

- a. Rent, rates, taxes, repairs and insurance for buildings used for the purpose of his profession.
- b. Repairs and insurance of machinery, plant and furniture used for the purposes of his profession
- c. Depreciation on buildings, machinery, plant or furniture owned and used for the purposes of profession;
- d. The amount of interest paid in respect of borrowals for the purposes of profession,
- e. Any sum paid as an employer by way of contribution towards a recognized provident fund or an approved superannuation fund or an approved gratuity fund.

In addition to the above mentioned items of expenditure, under sec.37 any other expenditure, which are not, in the nature of capital expenditure or in the nature of personal expenditure and which are incurred wholly, exclusively and necessarily for the purposes of the profession will also be allowed in computing the income chargeable under this head.

Some of such expenditures, which will qualify for deduction under this general category, are:

- i. Subscription to Medical Council;
- ii. Expenses in connection with attending medical conferences, in India or abroad;
- iii. Administration expenses towards travelling, telephone, salary to staff, professional charges paid to fellow doctors, electricity etc.
- iv. Subscription to books, periodicals etc.

Expenditure not Deductible

However, the following sums are not allowed as deduction while computing the professional income:

- a. Any income tax/wealth tax paid
- b. Any expenditure in respect of which payment is made to any relative of the assessee, which in the opinion of the Assessing Officer is excessive or unreasonable.

The expression “relative” in relation to an individual means the husband, wife, brother, or sister or any lineal ascendant or descendant of that individual.

Where a person has incurred any expenditure in excess of Rs. 20000 for the purpose of business, then actual payment towards such expenditure should be made only by crossed cheques or crossed bank draft. If such payment is not made by a crossed cheque or crossed draft, then 20% of the amount so paid will be disallowed while computing the income from profession.

Clubbing of income arising to spouse, son's wife, minor child: (sec.64 & 64(1A))

In computing the total income of any individual, any income arising directly or indirectly to the spouse in the following circumstances will also be included in the income of the individual concerned. They are:

- a. Any salary, commission, fees or any other form of remuneration paid to the spouse of an individual, from a concern in which such individual has substantial interest;

However, where the remuneration is solely attributable to the application of technical or professional qualification, knowledge and experience of the spouse, such remuneration cannot be clubbed. For example, where a medical practitioner pays salary to his wife who is also a qualified doctor, income will not be clubbed.

Substantial interest-meaning of-

An individual is deemed to have substantial interest in a concern-

- i. In case where the concern is a company he by himself or along with his relatives beneficially holds equity shares carrying not less than 20% of the voting power;
 - ii. In any other case, he by himself or together with his relatives is entitled to 20% of the profits of such concern.
- b. Where an asset is transferred to the spouse by that individual otherwise than for adequate consideration or in connection with an agreement to live apart, the income arising from such asset.

Similarly, if any individual transfers any asset to his or her son's wife, otherwise than for adequate consideration, then all such income arising directly or indirectly from such asset shall be included in the total income of that individual.

For example, if an individual gives gift of Rs. 50,000 to his wife or his daughter-in-law and the same is invested, say in a bank as fixed deposits, then the income therefrom will be included in the total income of such individual.

Minor's Income

- a. Under section 64 (1A) any income accruing or arising to a minor child will be included in the total income of that parent, whose income, excluding the income to be clubbed is greater.

- b. Once clubbing of minor's income is done with that of one parent it will not be clubbed with the other parent unless the Assessing Officer is satisfied, after giving the other parent an opportunity to be heard, that it is necessary so to do.
- c. Where the marriage of the parents does not subsist the income of the minor will be included in the income of the parent who maintains the minor child.

Under section 10(32), in the case of an assessee in whose total income the minor child's income is to be included u/s 64 (1A), exemption is given upto Rs.1500 (not exceeding the income clubbed) in respect of **each** such minor child.

- d. However, income of a minor, earned by him out his/her personal skill will not be clubbed with that of the parent and will be subject to tax as his own income.

Tax Planning for Minor Child

The investments in the name of the minor can be made in assets, the income from which are exempt from tax. Examples of such assets are-

Public provident fund, RBI relief bonds, 7% tax-free bonds, agricultural income. Agricultural income of minor cannot be aggregated with the parent's income for rate purposes. Investment can also be made through a trust and the trust deed can provide that the income from investments would accrue to the minor only on attaining of the age of majority. There are favourable decisions of various courts to this view.

Reference may be made to the decision of the Bombay High Court in Yogindra Prasad Mafatlal V. CIT 109 ITR 602 (Bom.).

Carry forward and set off of Losses –Sec.72.

Under Sec.72 where for any assessment year, the net result of the computation under the head “ Profits and gains from business or profession” is a loss to the assessee and such loss cannot be set off wholly against income under any other head then such loss shall be carried forward to the following assessment year and set off against the profits and gains of any profession carried on by him. However, no such loss shall be carried forward under this section for more than eight assessment years immediately succeeding the assessment year for which the loss was first computed.

Deductions under Chapter VIA

GENERAL

In computing the total income of an assessee, there shall be allowed from the gross total income deductions specified in sections 80 CCC to 80 U in chapter VIA. The aggregate amount of the deductions under this chapter shall not exceed the gross total income.

Deduction in Respect of Certain Payments

Sec.80 CCC: Contribution to certain pension funds upto Rs.10,000.

Sec.80 D: Mediclaim insurance premia on the health of the assessee, spouse, dependant and children upto Rs.10,000.

Sec.80 DD: Maintenance and medical treatment upto Rs.40,000.

Sec.80 DDB: Medical treatment for certain specified disease or ailment upto Rs.40,000.

Sec.80E: Repayment of loan taken for higher education from any approved institutions upto Rs.25,000 per annum.

Sec. 80G: Donations to certain funds. charitable institutions etc. upto 50% of the qualifying amount.

Sec.80L: Interest from Bank, NSC, Post office savings, government securities etc. Rs.12,000,

Sec.80U: Person who suffers from a permanent physical disability. Upto Rs.40000 per annum.

Rebates from Income Tax

In computing the amount of income tax payable on the total income, he will be entitled to deduct, from the amount of income tax he will be entitled to deduct the rebates specified under section 88, section 88B and section 88C.

However, the total amount of the deductions under sections 88, 88C and 88B shall not exceed the amount of income tax. For example the tax payable by a person for the assessment year 2003-04 is Rs.18,000 and the amount of deductions or rebates u/s 88/88B/88C is Rs. 20,000 then the total amount of deductions will be restricted to Rs.18,000 only. In other words he cannot claim refund of the excess deduction to which he is entitled.

Sec.88: Under this section certain specified payments and investments are eligible for deduction. The following are some of the payments/investments which qualify for tax rebate:

- LIC insurance premium paid;
- Unit linked insurance plans (ULIP)
- Contribution to public provident fund, recognised provident fund.

Investments in:

- National savings certificates;
- Post office savings cumulative deposits;
- Subscriptions to specified mutual funds;
- Housing loan repayments etc.

The amount of rebate under section 88 which an individual/HUF is be entitled deduct to a from the amount of income tax payable by him is calculated as under:

Gross Total Income	Rebate u/s 88
Rs.1,50,000 or less	20% of the investments
Between Rs.1,50,001 and Rs.5,00,000	15% of the investments
More than Rs.5,00,001	Nil

It may also be noted that-

- a. In the case of Life Insurance Premiums paid or the in respect of the spouse or child of such individual will also qualify for rebate.
- b. Contribution to Public Provident Fund Account in the name of the spouse or child will also be eligible for rebate.

Rebate u/s 88 B: Senior Citizens

An individual who has completed sixty-five years, or more at any time during the year is be entitled to a deduction form the income tax upto Rs.15,000. In other words, it means that, at the present rates an individual need not pay any tax if his total income is Rs.1,30,000 or less.

Rebate u/s 88 C: Women Assesseees

An individual being a woman, not covered by sec.88 B, is entitled to a deduction upto Rs.5000 from the income tax payable by her in respect of her total income irrespective of her age. In other words, it means that, at the present rates of tax she does not have to pay any tax if her total income is Rs. 80,000 or less.

Requirement for Maintenance of Accounts (Sec.44 AA)

Under Section 44AA of the Income Act, 1961 every persons carrying on medical profession shall keep and maintain such books of account and other documents as may enable the Assessing Officer to compute his total income in accordance with the provisions of the Act.

The Central Board of Direct Taxes (CBDT) by virtue of the powers conferred to it under the Act, has prescribed the books of account and other documents to be kept and maintained, the particulars to be contained therein and the form and the manner in which and the place at which they shall be kept and maintained.

These are contained in Rule 6F of the Income Tax Rules 1962.

BOOKS OF ACCOUNT TO BE MAINTAINED-RULE 6F

The books of account and other documents required to be maintained under Rule 6F are:

- i. Cash book
- ii. Journal – if the accounts are maintained according to the mercantile system of accounting
- iii. Ledger
- iv. Carbon copies of bills, wherever machine numbered or otherwise serially numbered, wherever such bills are issued by the person, and carbon copies of counter-foils of machine numbered or otherwise serially numbered receipts issued by him, if the amount exceeds Rs. 25.
- v. Original bills wherever issued to the person and receipts in respect of expenditure incurred by the person;

In case, such bills and receipts are not issued and the expenditure incurred doesn't exceed Rs.50, then the

payment vouchers prepared and signed by the person, if the cash book maintained by him does not contain adequate particulars in respect of expenditure incurred by him.

In addition to the above, a person carrying on medical profession shall keep and maintain the following:

A daily case register in Form 3C

- a. An inventory under broad heads as on the first and the last day of the year, of the stock of drugs, medicines and other consumable accessories used for the purpose of his profession.

Rule 6F provides that the requirement of maintenance of books shall not apply in case of any person if his **total gross receipts** in the profession do not exceed Rs.1,50,000 **in any one** of the three years immediately preceding the previous year. In case the profession has been newly setup in a year, then this requirement shall not apply for that year, if the gross receipts is not likely to exceed Rs.1,50,000 in that year.

PLACE WHERE THE BOOKS ETC. ARE TO BE KEPT

The books of account and other documents have to be kept and maintained by the person at the place where he is carrying the profession or where the profession is carried on in more places than one, at the principal place of his profession.

PERIOD FOR WHICH THE BOOKS ETC. ARE TO BE KEPT

The books of account and other documents, other than cash books and ledgers shall be kept and maintained for a period of 6 years from the end of the relevant accounting year.

FORM No. 3C

Date	Sl.No.	Patient's Name	Nature of professional services rendered, i.e. general consultation, surgery, injection, visit, etc.	Fees received	Date of receipt
(1)	(2)	(3)	(4)	(5)	(6)

Consequences for Non-compliance

If any person fails to keep and maintain any such books of account and other documents or fails to retain such books of account and other documents for the period specified, he may be directed to pay, by way of penalty, a sum of Rs.25,000. Hitherto, the amount of penalty varied from Rs.2,000 and Rs.1,00,000, but with effect from 01.06.2001, a fixed sum of Rs.25,000 may be levied under section 271A.

Compulsory Audit

Where, the gross receipts from profession in year exceed Rs.10 Lakhs, then the books of account have to be audited compulsorily by a Chartered Accountant and a report should be obtained from him and filed the Assessing Officer on or before 31st October every year.

Where the books of account are subject to compulsory audit under section 44AB, the Chartered Accountant auditing the books should certify, in his report, that the prescribed books have been maintained as required under section 44AA and Rule 6F.

If any person fails to furnish the audit report within time will be liable to penalty calculated at the rate of $\frac{1}{2}\%$ of the professional receipts of the year.

PERMANENT ACCOUNT NUMBER (PAN)

Every person who is assessable under the Income Tax Act is required to apply for allotment of PAN on or before 31st May of the relevant assessment year. For example, if a person has a taxable income for the previous year ended on 31.3.2003, i.e. assessment year 2003-04, he shall have to make an application for allotment of PAN.

In addition to the above, Rule 114B of the Income Tax Rules, lists out transactions in relation to which PAN is to be quoted.

RETURN OF INCOME

Under section 139(1) every person, if his total income or the total income of any other person in respect of which he is assessable under the Income Tax Act during the previous year exceeded the maximum amount not chargeable to tax, shall furnish a return of income within the due dates stipulated hereunder:

Assessee	Due dates
In case of a company	30th November
In the case of a non-company assessee:	
a. Where the accounts are required to be audited under the Income Tax Act or any other law or in the case of a working partner of a firm whose accounts are required to be under this Act	31st October
b. In a case where the total income includes income from business or profession but not falling under (a) above	31st August
c. In any other case	30th June

Any person who sustained loss in any previous year and claims that such loss should be carried forward for set-off

in a succeeding year(s) shall furnish a return of income within the above mentioned time.

Belated Return

Any person who has not furnished a return within the time specified can file a belated return at any time before one year from the end of the assessment year. For example, for the previous year (financial year) 1.4.2001 to 31.3.2002, the assessment year is 2002-03. If a person has not filed the return of income before the due date, i.e. 31st August 2002, then he can file the return belatedly on or before 31.3.2004, i.e. one year from the end of 31.3.2003.

However, he will be liable for payment of interest under section 234 A at the rate of 1.25% of the amount of balance tax payable by him after deducting the advance tax and tax deducted at source from the total tax payable by him in respect of his total income. He will also be liable to penalty of Rs.5,000 under section 271 F if he files the return before the end of the assessment year, i.e. before 31.3.2003.

DEDUCTION OF TAX AT SOURCE (TDS)

Persons other than individuals and HUFs are liable to deduct tax at source in respect of the payments made by them to any other person. Some of such important payments are as under:

Salary	(Sec.192) normal rates
Interest in excess of Rs.5,000	(Sec.194A) @
paid in a year	10%+Surcharge 5%
Contract Payments	(Sec.194C) @
	2%+Surcharge 5%
Rent in excess of Rs.120,000	(Sec.194-I) @
in a year	15%+Surcharge 5%
Fees for professional or	(Sec.194J) @
technical services in excess	5%+Surcharge 5%
of Rs.20,000 in a year	

When should TDS be made?

The tax has to be deducted at the time of credit of such sum to the account of the payee or at the time of payment thereof whichever is earlier.

When should TDS be paid?

The tax so deducted shall have to be paid to the credit of the Central Government as under:

- | | |
|-------------------|---|
| Salary- | within one week from the date of such deduction; |
| Other than salary | within one week from the end of the month in which the deduction is made. |
- a. Failure to deduct tax at source or failure to pay the tax deducted will attract interest and penalty.
 - b. The person in charge of deduction of tax has to issue certificate of deduction to the payee. He shall also file return of tax deducted at source in the prescribed form, every year on or before 30th of June. Failure to comply with these requirements will expose him to levy of penalty.
 - c. Hitherto all individuals and HUFs were not required to deduct tax at source.
 - d. From the assessment year 2003-04 (with effect from 1.6.2002) onwards even individuals and HUFs whose sales, turnover etc., had exceeded Rs.40 Lacs or in the case of professionals whose gross receipts from profession exceeded Rs.10 Lacs in the preceding year are also covered by the provisions relating to TDS and henceforth such individuals or HUFs also have to comply with the TDS requirements as stated herein above.
 - e. All persons to whom TDS provisions are applicable shall in addition to the permanent.

Account Number (PAN) shall have to obtain Tax Deduction Number (TAN) and quote the number so allotted in all the challans, certificates and returns.

ADVANCE TAX

Every person is required to estimate his total income (other than income from capital gains, winnings from lotteries etc.) of a year and pay atleast 90% of the total income tax payable thereon (after deducting the rebates, if any, from tax, and tax deducted at source) in advance i.e. during the year itself in installments as under:

30% of tax payable	by 15th September
60% of tax payable	by 15th December
and balance of tax payable	by 15th March

However if the total tax payable on the total income is less than Rs.5000, then tax need not be paid in advance.

Interest for Non-payment of Advance Tax

If a person, who is liable to pay advance tax fails to pay atleast 90% of the tax payable by him in advance he will be liable for interest under section 234 B on the amount of shortfall calculated at the rate of 1.25% per month or part thereof, till the actual payment of tax. Such interest is mandatory in nature and can be waived only by the Chief Commissioner, under certain specific circumstances.

If a person has not paid the advance tax on or before the due dates mentioned above, in addition to interest under section 234 B, he will also be liable for interest under section 234 C for deferment of advance tax on the shortfall in each such installment of tax calculated at the rate of 1.25% per month.

Example:

Advance tax payable on an estimated total income of

Rs.1,50,000 for the year ended on 31.3.2003 is Rs.19,950 (Rs.19000+surcharge @ 5% of Rs.950)

Method of Accounting

The Income Tax Act two methods of accounting are recognised while computing the I income from profession which are-

- i. Cash system
- ii. Mercantile system.

A person is required to employ regularly either of the above systems.

Under cash system, income or expenditure is recognised only in the year of actual receipt of income or actual payment of expenditure irrespective of the date of the bill raised for the services or the invoice received for the expenditure.

For example, a medical practitioner raises a bill on a patient for his services in connection with a surgery on 28th of March 2002. The payment in respect of the bill was received only on 3rd April 2002. In such a case the fees will be included in the total income of the doctor for the year ended 31.3.2003 only and not in the year total income of the year for the year ended 31.3.2002, since it was received only after 1.4.2002.

On the other hand under the mercantile system of accounting the date of receipt/payment is not the criteria for determining the year of taxability of an item of income or allowability of an item of expenditure. Only the date of the bill or the date of invoice will be relevant. In the above example, the professional fees will be included in the total income of the year ended on 31.3.2002 and not 31.3.2003.

A person is permitted to follow either of the systems of accounting regularly. His income from profession will be computed only in the system employed by him. Once, he opts to follow a system, then he is not allowed to change

that system so adopted by him. Moreover, he has to follow only one system of accounting both in respect of income as well as expenditure. He is not permitted to follow one system for expenditure and another for income.

Some Important Penal Provisions

Although there are large numbers of penal provisions, the following are very important.

1. **Concealment of income:** In case a person is found to have concealed income, in addition to income tax payable by him on the income so concealed he will be liable to penalty under section 271(1)(c) of minimum 100% and maximum of 300% of the tax on the income so concealed.
2. If any person accepts any deposit or takes any loan in excess of Rs.20,000 otherwise than by A/c Payee cheque/draft then he shall be liable to penalty of a sum equal to the sum so accepted (Sec.269 SS).
3. If any person repays any deposit or loan, the balance of which together the interest exceeds Rs.20000 otherwise than by A/c Payee cheque/Draft then he shall be liable to penalty of a sum equal to the sum so repaid (Sec.269T).

Mr. X is a Doctor practicing in Delhi. Following is his receipts and payments for the year ended 31.03.2003:

RECEIPTS

Professional fees	3,00,000
Dividend for companies	8,000
House rent receipts	50,000
Loan from wife for car purchase	100,000
Salary from a private hospital	1,20,000
Interest from bank deposits	10,000

PAYMENTS

Salary to staff	48,000
Rent	24,000
Medical council fees	3,000
Telephone expenses	12,000
Sundry dispensary expenses	12,000
Car expenses (1/4th used for personal)	8,000
Purchase of car (15.06.2002)	1,15,000
Advance income tax	
15.9.2002	15000
15.12.2002	15000
15.3.2003	15000
Household expenses	72000
Municipal taxes paid for house	5000
Repairs to house	1500
Insurance for house	1500
LIC premium	15000
Medi-claim insurance (paid by cheque)	3,860
Income tax deducted on salaries (TDS)	8,000

Due date for filing the return is 31st July.

Date of filing of return is assumed to be on 02.09.2003.

Statement of Total Income

Heads of Income	Schedule	
Ref.		
Income from salary	(A)	90,000
Income from house property	(B)	31,500
Income from profession	(C)	1,77,750
Income from other sources	(D)	18,000
GROSS TOTAL INCOME	(E)	3,17,250
DEDUCTIONS	(F)	-15,860
TOTAL INCOME	(G)	3,01,390
TAX PAYABLE	(H)	13,900

Schedules to Statement of Total Income**A. Income from Salary**

Salary	1,20,000
Less: Statutory deduction u/s 16(1)	30,000 90,000

Standard deduction of Rs. 30,000 U/S 16(l) of the Income Tax Act has been given since the salary income after considering all the perquisites is below Rs.1,50,000.

B. Income from House Property

Rent received	50,000
Less: Municipal taxes	5,000
Annual value	45,000
Less: Standard allowance u/s 24 @30% on annual value	13,500 31,500

While computing the income from property let out, a standard allowance calculated @ 30% of the Annual Value is allowed towards repairs, rent collection charges etc., irrespective of the actual amount spent.

C. Income from Profession

Professional receipts	3,00,000
Less: Expenses incurred	
Salary	48,000
Rent	24,000
Sundry expenses	12,000
Medical council fees	3,000
Telephone	12,000
Car expenses (3/4th of 8000)	6,000
Depreciation ($115000 \times 20\% \times \frac{3}{4}$)	71,250 1,22,250

Motor Car has been partly used for professional purposes and partly for personal purposes. Therefore, expenditure proportionate to the estimated use for professional purposes is deductible.

For the same reason proportionate amount of depreciation is only allowable.

D. Income from Other Sources

Dividend from companies	8,000
Interest from bank	10,000 18,000

E. Gross Total Income 3,17,250

F. Less deduction u/s 80 D-mediclaim	-3,860
Less deduction u/s 80 L-bank interest and dividend restricted to	-12000

G. Total Income 301390

Note: As per Sec.80-D deduction for payment of medical premia will be allowed if it is paid either by cheque or demand draft only and not by cash.

Income tax there on (Vide note 1)	64,420	
Less. Rebate u/s 88		
LIC Premium	15,000 @ 15%	2250
Balance	62,170	
Add: Surcharge @ 5%	3,110	
Balance	65,280	
Less: TDS on Salaries	8,000	
Balance payable as advance tax	57,280	
Less: Advance tax paid		
15.09.2002	15,000	
15.12.2002	15,000	
15.03.2003	15,000	45,000
Balance Payable as Self-Asst. Tax	12,280	
Interest u/s 234 A (vide Note 2)	310	
Interest u/s 234 B (vide Note 3)	920	
Interest u/s 234 C (vide Note 4)	390	
H. Payable u/s 140 A	13,900	

1. Calculation of Income tax :-

Total Income	Tax
Upto Rs.50000	NIL
Rs. 50,001 to Rs. 60,000 @ 10%	1,000
Rs. 60,001 to Rs. 1,50,000 @ 20%	18,000
Balance over Rs. 1,50,001	<u>45,420</u>
	64,420

2 a) Interest for delayed submission of Return (Sec.234A)

Return of income should be filed with in the due date as per section 139(1) of the Income Tax Act. If the return is not filed within the due date then interest @ 1.25% for every month on the balance tax will be charged. For the purpose of interest a delay of one day will be considered as one month. Hence in this case there is a delay of two months.

Interest u/s 234 A is $12280 \times 1.25\% \times 2$ **310**

3 b) Interest for short payment of advance tax (Sec.234B)

A person has to pay atleast 90% of the assessed tax as advance tax before the end of the year. In this case the assessee has paid only less than 90% of tax as advance.

Hence he is liable for interest u/s 234 B as under:

Shortfall in Advance tax 12280

Interest @ 1.25% per month from 1.4.2002 for 6 months **920**

4 c) Interest for short payment of advance tax and deferment of advance tax are calculated as under (Sec.234C),

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Advance tax has to be paid on the due dates as under:

- i) Not less than 30% of the total advance tax payable – on or before 15th September 2002.
- ii) Not less than 60% of the total advance tax payable – on or before 15th December 2002.
- iii) Balance on or before 15th March

Interest @ 1.25% per month on the amount of shortfall in each instalment is payable.

Calculation of interest u/s 234 C:

			Shortfall		Interest
234C(1):	57280 x 30%	17190			
	Paid on 15.09.2002	- 15000	2190	1.25% for 3 months	80
234C(2):	57280 x 60%	34370			
	Paid before 15.12.02	- 30000	4370	1.25% for 3 months	160
234C(3):	Balance		12280	@ 1.25%	150
			TOTAL INTEREST		390

Chapter 18

Dentists/Maxillofacial Surgeons as Expert Witnesses

Dentists and maxillofacial surgeons are often called upon to give evidence in case of civil or criminal cases. When a dentist is called upon to give evidence as part of forensic evidence he needs to have a grasp of the subject. Forensic odontology has been used extensively and it will be dealt with in a separate chapter. Forensic odontology has been used in many sensational cases in India. The Rajiv Gandhi assassination being one of the better-known ones.

Dental Surgeons are often called up in other more common situations as well.

1. Evaluation of disability after dental or maxillofacial injuries.
2. For opinions regarding the procedures adopted by other doctors/dentists in cases of alleged negligence.

Expert witnesses are issued summons as discussed earlier in the chapter. The dentist is obliged to present himself before the court at the appointed time. He may be questioned by the lawyers of the prosecution, defence or the insurance company, as to the nature of injury and the quantum of disability. The dentist is to clearly state his opinion without ambiguity and should remain non-committal about subjects that he is not sure about. If the dentist has issued a wound certificate, the copy of the same will be given to him for reference at the time of testifying. The witness is to merely state the facts. He is not expected to involve himself with law on the subject. For example, Loss of teeth, fracture of teeth etc. He may answer truthfully any other question pertaining to the same.

Today, there does not exist any quantified disability criteria for dental and maxillofacial impairment in India. The Association of Oral and Maxillofacial Surgeons is in the process of evolving criteria for dental and maxillofacial disabilities and deformities. Until such time dentists can use the rather incomplete reference from 'The Manual for Permanent Disability' brought out by the CGHS, WHO and AIIMS in 1981. Other references can be obtained from Mc Brides disability criteria or the criteria established by the American Association of Oral and Maxillofacial Surgeons (which may not be very relevant to our population). However a dentist may state if the injury is grievous or not. He may also elaborate on the actual disability that the defect might cause.

Examples of grievous injuries are:

1. Loss of teeth.
2. Fracture of teeth.
3. Avulsion of teeth.
4. Non-vitality of teeth.
5. Fracture of any facial bone.
6. Loss of soft tissue and severe scarring.
7. Neurological deficit (motor or sensory).

The author has proposed recommendations for disability and deformity based on a number of Indian and overseas criteria. This may be accepted after critical review. The rationale for such a criteria is also discussed.

QUANTIFICATION OF DENTO-FACIAL DISABILITY/DEFORMITY—A PROPOSAL (George Paul and Sam Thomas 2003)

Form and function are the quintessence of human life. Disability and deformity are interruptions to this harmony. Disability/deformity may be congenital or acquired. Governments have a social responsibility to mitigate such

afflictions by creating an environment for re-integrating them into normal social life. Most welfare states provide benefits for persons with disability.

Disability can also be caused by accidents, interpersonal violence and iatrogenic causes. These situations have legal overtones and often require compensation in some form. Benefits and compensation can only be calculated if the disability is quantified. Orthopedic disabilities in civil and military life have been calibrated and quantified. Similarly, other disabilities involving loco motor, neurological, visual and hearing deficit have also been quantified. Unfortunately, the maxillofacial region has not been adequately addressed in any of these quantification charts.

Quantification of the maxillofacial region is unique on account of the fact that there are two criteria to be evaluated- disability and deformity. While disability is more readily calculated, deformity is highly subjective and therefore any award for the latter is bound to be arbitrary. However, it is not possible to ignore the importance of deformity to the face, and an attempt is made to establish a broad parameter in which it can be assessed.

Review of Quantification Criteria

Quantification of orthopedic disability is well established and has been in use for social benefits, rehabilitation, assistance and percentage reservations in labour market placement of disabled people. It has also been in use for legal and insurance compensations due to accidents, interpersonal violence and occupational diseases. The Phulhems profile by the Canadian Army was established as early as 1943. The McBrides criteria was the established reference in India till 1980. It did cover some aspects of the maxillofacial region and was generally accepted for dental injuries and dental loss. The McBrides criteria (1955)

was replaced in India by the “Manual for Doctors to Evaluate Permanent Physical Impairment” (1981). Unfortunately, the impairment and disability of the face is covered rather incomprehensively and inadequately, relegating the whole area of the face to one half of a chapter, with hardly 30 points being allocated to the face. Not one maxillofacial surgeon sat on the expert committee of 45 advisors. In the realm of physical rehabilitation and orthopedics, numerous references are available. Kessler (1970) covered various aspects of upper and lower extremity disabilities. The American Academy of Orthopedic Surgeon’s Manual (1966) discusses the concept of permanent impairment through a series of questions that reveal the permanency of the deficit. The Govt. of India notification⁸ (1986) covers visual disabilities, locomotor disabilities and hearing, and speech disabilities. It recommends that Kessler’s formula can be taken as a general guideline.

Significantly, the only other Indian guideline for maxillofacial region comes through a Government of Tamilnadu notification (1974) where complete facial disfigurement is dealt with. It simply awards a 50% for total facial disfigurement. No break up figures is given for type or severity of disfigurement.

The American Association of Oral and Maxillofacial Surgeons and American Medical Association have given guidelines for assessment of maxillofacial injuries and disabilities. They however need modification to suit our population and needs.

The author has depended on two major sources while making this evaluation.

1. Objective evaluation of impairment and ability in locomotor handicapped by Sabapathyvinayagam Ramar. An excellent reference book on Physical Medicine and Rehabilitation.

2. Guidelines to the Evaluation of Impairment of The Oral and Maxillofacial Region—issued by the American Association of Oral and Maxillofacial Region.

The author has modified the guidelines of the above sources to arrive at the recommendations.

The general aim of the exercise was to evolve quantification criteria for disabilities and deformities of the maxillofacial region taking into account the special features of the problems encountered in India. It also endeavours to simplify the percentages awarded by eliminating complex variables. *The evaluation adopts a position of awarding a 100% to the face to be divided between deformity (50%) and disability (50%). It does not try to evaluate facial impairment as a part of the total body as it would significantly reduce the quantum of impairment and thus defeat the purpose of this exercise.* Consider a situation where 100% has to be divided between cardiovascular, alimentary, central nervous and locomotor systems in addition to sexual dysfunction, liver dysfunction, renal, endocrine and metabolic dysfunctions. Further distribution amongst visual, hearing, etc. will certainly minimize any help of giving value to the face.

The evaluation has also eliminated the need to go into variables like age, sex and occupation, which will modify the award percentages. These will rest within the realm of the government agencies, judiciary or insurance agents.

The criteria formulated shall simply make a statement of disability/deformity based on standards established within the purview of the 100% for the face – equally divided amongst the various structures and functions. *The total of these shall remain within hundred utilizing the formula*

$$A + B \frac{(100 - A)}{100}$$

where, A = higher value and
B = lower value.

Definitions

Based on Govt. of India Gazette Part I section 1 No. 4-2/83 – HW III Ministry of Welfare, 1986.8

Impairment is defined as any loss (or) abnormality of psychological, physiological (or) anatomical structure (or) function.

Disability: WHO defines disability in the context of health experience as any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner (or) within the range considered normal for a human being.

Deformity: Facial disfigurement involving soft and hard tissues arising from multiple genetic factors, environment influences, acquired defects, neoplastic processes and trauma.

Recommended Quantification for the Dento-facial Region

Areas of Deformity Evaluation—Hard Tissues

A. Loss of Teeth:

<i>Anteriors</i>	<i>Deformity/ Disability</i>
All anteriors (upper and lower)	: 25%
Between 8 and 11	: 20%
Between 4 and 7	: 15%
Between 2 and 3	: 10%
One tooth	: 05%

Though these are disabilities and deformities that can be replaced, it deserves the above percentile as the strength and function of false teeth are not considered equal to natural teeth. Orthopedic deformities are evaluated even if prosthesis is given.

<i>Posteriors</i>	<i>Disability</i>
- Excluding third molars and including premolars.	
All posteriors (16)	: 25%

Between 10 and 14	: 20%
Between 6 and 9	: 15%
Between 2 and 5	: 10%
Occlusal discrepancy	: 10%-20%
One tooth	: 05%

Loss of teeth due to progressive dental pathology (e.g. Periodontitis, Caries) are not considered. The dental surgeon will have to make an assessment based on the condition of remaining teeth or preexisting records.

B. Loss of bone

Disability/ Deformity

Significant loss of bone causing deformity/Disability	:10-25%
Small bony fragment	: 5%

C. Malunited facial bones

(depending on extent of disability/deformity)

Malunited facial bones 10%-20%

- Occlusion to be combined whenever affected.

This is an incomplete quantification and will have to be assessed by the surgeon on the basis of the degree of disability/ deformity caused by the malunion.

D. Orbital Deformity(excluding visual field assessment)

Subjective evaluation based on:

Bony orbit :	5-10%
Soft tissue eg) etropian, scar etc :	5-10%
Composite deformities including Telecanthus etc :	15-25%

Areas of deformity evaluation–soft tissue

A. Soft Tissue – Non-reversible

Single linear scar	: 5%
--------------------	------

Multiple or deforming scars	
Including Keloids	: 10-30%
Significant loss of soft tissue	
e.g. Loss of nose, ear, lips etc	: 20-50%

B. *Facial Sensory Impairment (Ramar)*

- Face has 34% sensory innervations of whole body.

Ophthalmic	: 8%
Maxillary	: 8%
Mandibular	: 8%
Tongue	: 10%

C. *Impairment rate for mouth opening (Ramar)*

Impairment rate for interincisor distance of 4cms : 0%

Impairment rate for interincisor distance of 3cms : 10%

Impairment rate for interincisor distance of 2cms : 20%

Impairment rate for interincisor distance of 1cm : 30%

Impairment rate for interincisor distance of 0cm : 50%

D. *Motor disability (Ramar)*

Jaw muscles (masticatory) : 5% right side, 5% left side

Tongue muscles : 15% either side.

E. *Facial nerve impairment*

Single branch : 05%

Five branches : 25%

Zygomaticotemporal : 10%

Bilateral problems are not addressed.

F. *Disfigurement criteria (AAOMS and AMA guidelines 1997 and 2002)*

Class 1-(0-5%) Disorder of cutaneous structure eg visible scars.

Class 2-(5-10%) Loss of supporting structure with or without cutaneous disorder, e.g. depressed cheek and nose.

Class 3-(10-15%) Absence of normal anatomical area of face. For example, loss of eye or part of nose. Visual or hearing loss will have to be separately evaluated.

Class 4-(15-35%) Impairment of whole person. Facial disfigurement is so severe that it precludes social acceptance.

This criteria appears logical and it significantly simplifies an otherwise complex quantification of facial disfigurement. However, we would encourage its use with the other mentioned parameters. The multiple percentages can be resolved with the Kessler's formula.

In multiple disabilities and deformities or when there is a combination of the two the Kessler's Formula $A + \frac{B(100-A)}{100}$ can be used,

where A= the higher and B= lower value

Another formula has also been used by Ramar as per the Government of India notification: $A + \frac{B(90-A)}{90}$ again A being the higher value and B being the lower value.

The formula can be used in a few mock situations.

1. X has an injury resulting in the fracture of the mandible and loss of four incisors. He also develops a paresis of the marginal mandibular nerve following surgery. His total percentile may be calculated thus: A= 15% and B= 5%. $15 + \frac{5(100-15)}{100} = 19.25$, whereas the sum of both would

have been 20%.

2. Y has an injury resulting in the fracture of both condyles causing subsequent total bony ankylosis. He also has a large scar with keloid on his right cheek. His percentage is calculated thus:

$50 + \frac{20(100-50)}{100} = 60$ whereas the sum of two injuries

would have been 70. Please note that the value adjusts itself as the percentiles go up.

Discussion

Quantifying all kinds of disabilities/deformities is an enormous task. This paper attempts to deal with only those disabilities resulting from accidents. Congenital disabilities/deformities such as those found in cleft – craniofacial anomalies will require a more extensive analysis. Similarly, disabilities and deformities caused by aggressive tumours and cancers of the head and neck comprise a wide range of problems, which are not necessarily regional. Cancer in particular may have numerous associated problems ranging from donor site morbidity to psychological impact affecting quality of life and mental depression.

Dental injuries and their resultant disability/deformity are closely linked to aesthetics and mastication. For the purpose of awarding percentiles, the anterior teeth were considered for aesthetics and the posterior teeth for masticatory function. The awards are arbitrary and based on the relative dysfunction caused by the absence of teeth in the masticatory apparatus. The American Association of Oral and Maxillofacial Surgery (AAOMS) guidelines award percentages for the complete masticatory apparatus. It awards 24% for a person who is restricted to liquid diet (40%-60% if tube feeding is necessary) and 5-19% if person is restricted to semisolids (includes those with ability to wear dentures). We have taken the liberty of awarding points for individual teeth. However if the whole masticatory apparatus is to be evaluated, one may separately evaluate absence of teeth, occlusal disharmony, TMJ movement (craniomandibular articulation), muscle power etc and arrive at a figure by using the Kessler's formula of
$$\frac{A + B(100-A)}{100}$$

This appears as a reasonable formula, which accounts for individual disabilities within the framework of the masticatory apparatus.

Further, the AAOMS guidelines classifies the percentiles into two categories 1. Percentage of normal. 2. Percentage impairment of whole person. The dichotomy does not seem reasonable and is likely to cause further confusion. Finer details such as lateral excursion etc which, have been dealt with in the AAOMS guidelines have been ignored.

Similarly, the concept of deformity and disfigurement has been dealt with differently in the AAOMS and the AMA guidelines. The matter of disfigurement is complicated by issues such as personality crisis and the impact of social acceptance. As suggested earlier this criteria can be incorporated into Kessler's formula, thus resolving the issue of multiple disabilities and deformities.

Finally, the question of who can give a disability certificate. The Indian sources are silent in the matter of maxillofacial injuries. However, the law in many American states clearly provides for the role of a board qualified oral surgeon or maxillofacial surgeon to issue disability certification for the maxillofacial region.

Contrary to general perception, it is not necessary that these criteria need to be made by statutory bodies. General usage can give legal legitimacy. It would of course be in the best interest of the surgeon, patient and the public if these suggestions can be scrutinized, amended and enlarged to accommodate a larger spectrum of disabilities and deformities.

Duties of Witness

Failure to appear in court without valid reasons after warrant has been issued can invite contempt of court. Exaggeration or false statements given under oath is not only unethical, but can invite punishment under sec.181, sec.193.

FAQs

What is standard of proof? Why is it different for civil and criminal cases?

It denotes the amount of proof required as evidence. In civil cases the quantum of proof required is less than in criminal cases. A high degree of probability or even circumstantial evidence may suffice as evidence in a civil case, however in criminal cases the evidence must be beyond reasonable doubt. This is because the punishment in criminal cases is more severe and an innocent person must not be punished unless his guilt is beyond doubt.

Is it enough to get expert evidence as an affidavit? Does the expert have to come to testify in court?

In a civil or criminal case an expert may need to testify in person under oath. This will give the opposite party to cross-examine him also. An affidavit is a weak evidence as he cannot be examined under oath by the other party. However, affidavits are accepted as evidence in consumer courts.

How is the jurisdiction of the court decided? Can an objection be made?

Jurisdiction may be original, appellate, pecuniary or territorial. As a rule a case is heard in the lowest court competent to hear it. A case cannot be filed directly in a high court or supreme court, if it can be heard in a competent lower court. One may appeal to a higher court in case of dissatisfaction with the ruling of a lower court (appellate jurisdiction). In pecuniary jurisdiction, it is the plaintiff's valuation in the plaint that determines jurisdiction. For example, a claim for less than 5 lakhs will be heard in the district forum (Consumer cases) and so on.

With regard to territorial jurisdiction, the suit is instituted, where the subject matter is situated. If the suit is for compensation for wrong done and if the wrong was done in one place and the defendant is in another place, a suit can be filed at either of the two places at the option of the plaintiff. **In all other cases** the suit should be instituted only at the place where the defendant or one of the defendants (if there are more than one) resides or carries on business. The plaintiff or defendant can appeal a wrong jurisdiction.

Is it necessary to reply to a lawyer's notice?

While it is not mandatory to reply to a lawyer's notice, it is sensible to do so, particularly if the allegation is mischievous or frivolous. The other party can be made to understand your intention and that the allegation will be contested. Most complaints of negligence can be sorted out by a strong and effective reply to the allegations in the notice.

Is a dentist bound to attend court if called to give evidence?

Yes! A court summons has to be obeyed.

Does a dentist have to wear an overcoat/ apron when appearing in court?

Many judges insist on doctors/dentists wearing a coat while giving evidence. Government doctor's on duty have to wear the white coat as it is their uniform. Private practitioners giving evidence are not bound by this rule. However it may be better to carry your coat than to argue with the court officials.

Appendices

Appendix 1

Relevant Statutory Provisions

INDIAN PENAL CODE, 1860

S.88. Act not intended to cause death, done by consent in good faith for person's benefit—Nothing, which is not intended to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the order to be likely to cause, to any person for whose benefit it is done in good faith and who has given a consent, whether express or implied, to suffer that harm, or to take the risk of that harm.

S.89. Act done in good faith for benefit of child or insane person, by or by consent of guardian—Nothing which is done in good faith for the benefit of a person under twelve years of age, or of unsound mind, or by consent, either express or implied of the guardian or other person having lawful charge of that person, is an offence by reason of any harm which it may cause, or be intended by the doer to cause or be known by the doer to cause or be known by the doer to be likely to cause to that person; provided,

Provisions

First—That this exception shall not extend to the intentional causing of death.

Secondly—That this exception shall not extend to the doing of anything which the person doing it knows to be likely to cause death, for any purpose other than the preventing of death or grievous hurt, or the curing of any grievous disease or infirmity.

Thirdly—That this exception shall not extend to the voluntary causing of grievous hurt, or to the attempting to cause grievous hurt, unless it be for the purpose of

preventing death or grievous hurt, or the curing of any grievous disease or infirmity;

Fourthly—That this exception shall not extend to the abatement of any offence, to the committing of which offence it would not extend.

Ss.304-A—Causing death by negligence—Whoever causes the death of any person by doing any rash negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

Ss.319—Hurt—Whoever causes bodily pain, disease or infirmity to any persons is said to cause hurt.

Ss.336—Endangering human life or personal safety—Whoever does any act so rashly or negligently as to endanger human life or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to three months, or with fine which may extend to Rs 250 or with both.

Ss. 337—Causing simple hurt by negligent act.—Whoever causes hurt to any person by doing any act so rashly as to endanger human life or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine upto Rs 500/, or with both.

S.338—Causing grievous hurt by act endangering life or personal safety of others—Whoever causes grievous hurt to any person by doing any act so rashly or negligently as to endanger human life, or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine which may extend to one thousand rupees or with both.

CODE OF CRIMINAL PROCEDURE, 1973

a. S.41—When police may arrest without warrant—

(1) Any police officer may without an order from a

Magistrate and without a warrant arrest any person—

(a) who has been concerned in any cognizable offence or against whom a reasonable complaint has been made, or creditable information has been received, or a reasonable suspicion exists, of his having been so concerned; or

(b) who has in his possession without lawful excuse, the burden of proving which excuse shall lie on such person any implement of house breaking; or

(c) who has been proclaimed as an offender either under this code or by order of the State Government; or

(d) in whose possession anything is found which may reasonably be suspected to be stolen property and who may reasonably be suspected of having committed an offence with reference to such thing; or

(e) who obstructs a police officer while in the execution of this duty, or who has escaped, or attempts to escape, from lawful custody; or

(f) who is reasonably suspected of being a deserter from any of the armed forces of the Union; or

(g) who has been concerned in, or against whom a reasonable complaint has been made, or creditable information has been received, or a reasonable suspicion exists, of his having been concerned in, any act committed at any place out of India, which, if committed in India, would have been punishable as an offence, and for which he is, under any law relating to extradition, or otherwise, liable to be apprehended or detained in custody in India; or

(h) who being a released convict, commits a breach of any rule, made under sub-section (5) of section 356; or

(i) for whose arrest any requisition, whether written or oral, has been received from another police officer, provided that the requisition specifies the person to

be arrested and the offence or other cause for which the arrest is to be made and it appears therefrom that the person might lawfully be arrested without a warrant by the officer who issued the requisition.

- (ii) Any officer in charge of a police station may, in like manner, arrest or cause to be arrested any person, belonging to one or more of the categories of persons specified in section 109 or section 110.

CONSTITUTION OF INDIA

a. Article 20(1)

Protection in respect of conviction for offences—No person shall be convicted of any offence except for violation of a law in force at the time of the commission of the act charged as an offence nor be subjected to penalty greater than that which might have been inflicted under the law in force at the time of the commission of the offence.

b. Article 20(2)

No person shall be prosecuted and punished for the same offence more than once.

c. Article 20(3)

No person accused of any offence shall be compelled to be a witness against himself.

d. Article 21

Protection of life and personal liberty—No person shall be deprived of his life or personal liberty, except according to the procedure established by law.

INDIAN CONTRACT ACT, 1972

1. What agreements are contracts—All agreements are contracts if they are made by the free consent of parties competent to contract, for a lawful consideration and with

a lawful object, and are not hereby expressly declared to be void.

Nothing herein contained shall effect any law in force in India, and not hereby expressly repealed, by which any contract is required to be made in writing or in the presence of witnesses, or any law relating to the registration of documents.

2. Who are competent to contract—Every person is competent to contract who is of the age of majority according to the law to which he is subject, and who is of sound mind and is not disqualified from contracting by any law to which he is subject.

3. What is sound mind for the purpose of contracting - A person is said to be of sound mind for the purpose of making a contract if, at the time when he makes it, he is capable of understanding it and of forming a rational judgement as to its effect upon his interests.

A person who is usually of unsound mind, but occasionally of sound mind, may make a contract when he is of sound mind.

A person who is usually of sound mind, but occasionally of unsound mind, may not make a contract when he is of unsound mind.

4. “Consent” defined—Two or more persons are said to consent when they agree upon the same thing in the same sense.

5. “Free consent” defined—Consent is said to be free when it is not caused by:

1. Coercion, as defined in sec.15, or
2. Undue influence, as defined in sec.16, or
3. Fraud, as defined in sec.17, or
4. Misrepresentation, as defined in sec.18, or
5. Mistake, subject to the Provisions of secs. 20, 21 and 22. Consent is said to be so caused when it would not have been given but for the existence of

such coercion, undue influence, fraud, misrepresentation, or mistake.

6. “Coercion” defined—“Coercion” is the committing or threatening to commit, any act forbidden by the Indian Penal Code (45 of 1860); or the unlawful detaining, or threatening to detain, any property, to the prejudice of any person whatever, with the intention of causing any person to enter into an agreement.

Explanation—It is immaterial whether the Indian Penal Code (45 of 1860), is or is not in force in the place where the coercion is employed.

7. “Undue influence” defined—(1) A contract is said to be induced by “undue influence” where the relations subsisting between the parties are such that one of the parties is in a position to dominate the will of the other and used that position to obtain an unfair advantage over the other.

(1) In particular and without prejudice to the generality of the foregoing principle, a person is deemed to be in a position to dominate the will of another.

(a) where he holds a real or apparent authority over the other, or where he stands in fiduciary relation to the other; or

(b) where he makes a contract with a person whose mental capacity is temporarily or permanently affected by reason of age, illness, or mental or bodily distress.

(2) Where a person who is in a position to dominate the will of another, enters into a contract with him, and the transaction appears, on the face of it or on the evidence adduced, to be unconscionable the burden of proving that such a contract was not induced by undue influence shall lie upon the person in a position to dominate the will of the other.

Nothing in this sub-section shall affect the provisions of sec. III of the Indian Evidence Act, 1872 (1 of 1872).

8. “Fraud” defined—“Fraud” means and includes any of the following acts committed by a party to a contract, or with his connivance, or by his agent, with intent to deceive another party there to or his agent or to induce him to enter into the contract:

- (1) the suggestion, as a fact, of that which is not true, by one who does not believe it to be true;
- (2) the active concealment of a fact by one having knowledge or belief of that fact;
- (3) a promise made without any intention of performing it;
- (4) any other act fitted to deceive;
- (5) any such act or omission as the law specially declares to be fraudulent.

Explanation—Mere silence as to facts likely to affect the willingness of a person to enter into a contract is not fraud unless the circumstances of the case are such that, regard being had to them, it is the duty of the person keeping silence to speak, or unless his silence is, in itself equivalent to speech.

9. “Misrepresentation” defined—“Misrepresentation” means and includes.

- (1) the positive assertion, in a manner not warranted by the information of the person making it, of that which is not true, though he believes it to be true;
- (2) any breach of duty which, without an intent to deceive, gains an advantage to the person committing it, or any one claiming under him, by misleading another to his prejudice, or to the prejudice of any one claiming under him;
- (3) causing, however innocently, a party to an agreement to make a mistake as to the substance of the thing which is the subject of the agreement.

10. Voidability of agreement without free consent—When consent to an agreement is caused by coercion, (Repealed by Act 6 of 1899, Sec.3 (The words, “undue influence”)) fraud or misrepresentation, the agreement is a contract voidable at the option of the party whose

consent was so caused. A party to a contract, whose consent was caused by fraud or misrepresentation, may, if he thinks fit, insist that the contract shall be performed, and that he shall be put in the position in which he would have been if the representation made had been true.

Exception—If such consent was caused by misrepresentation or by silence, fraudulent within the meaning of sec.17, the contract, nevertheless, is not voidable, if the party whose consent was so caused had the means of discovering the truth with ordinary diligence.

Explanation—A fraud or misrepresentation which did not cause the consent to a contract of the party on whom such fraud was practiced, or to whom misrepresentation was made, does not render a contract voidable.

11-A. Power to set aside contract induced by undue influence—When consent to an agreement is caused by undue influence, the agreement is a contract voidable at the option of the party whose consent was so caused. Any such contract may be set aside absolutely or, if the party who was entitled to avoid it has received any benefit thereunder, upon such terms and conditions as to the court may seem just.

12. Agreement void whether both parties are under mistake as to matter of fact—Where both the parties to an agreement are under a mistake as to a matter of fact essential to the agreement is void.

Explanation—An erroneous opinion as to the value of the thing which forms the subject-matter of the agreement, is not to be deemed a mistake as to a matter of fact.

13. Effect of mistakes as to law—A contract is not voidable because it was caused by a mistake as to any law in force in (India)*; but a mistake as to a law not in force in (India)* has the same effect as a mistake of fact. *Substituted for the words, "British India", by A.O. 1948 and by A.O.1950.

14. Contract caused by mistake of one party as to matter of fact—A contract is not voidable merely because it was caused by one of the parties to it being under a mistake as to a matter of fact.

15. What considerations and objects are lawful, and what not—The consideration or object of an agreement is lawful, unless –

- It is forbidden by law or
- Is of such a nature that, if permitted, it would defeat the provisions of any law; or is fraudulent or;
- Involves or implies injury to the person or property of another; or the court regards it as immoral, or opposed to public policy.
- In each of these cases, the consideration or object of agreement is said to be unlawful. Every agreement of which the object or consideration is unlawful, is void.

Appendix 2

Consent Form

BENCHMARK IDENTIFICATION

Particulars of patient:

- a. Name
- b. Age
- c. Sex
- d. Status
- e. Physical status

Particulars of Attendant / Parent / Guardian / Friend /
Accompanying person

- a. Name
- b. Age
- c. Sex
- d. Status
- e. Relationship with the patient

Consent for what purpose

- a. Surgery

Whether the patient/parent/guardian and the like has/have
been furnished with information relating to the proposed
surgical intervention or treatment or pathological
examination.

“Information” as to what?

- a. Need
- b. Doctor’s advice
- c. Risk
- d. Financial implication
- e. Impact on life style
- f. Alternatives
- g. Procedure and the like

Whether this information has been told to the patient in the language known to him/her.

Highlights of the information provided

.....
.....
.....
.....

Though consent is given to the doctor for a specific act of intervention, for any unforeseeable or non-contemplated thing or development or fact, the doctor is entitled to do or undertake anything which he/she considers to be in the best interests of the patient even without consent.

Under no circumstances patient can hold doctor or hospital harmless in terms of legal liability.

Under no circumstances, patient can exonerate either hospital or doctor or health professional from any kind of legal liability in an absolute sense. To this effect, these cannot be a contractual term in the contract, as it would be void on account of opposed to public policy.

The hospital or doctor or health professional is entitled to seek exoneration of legal liability by incorporating a suitable clause in the contract only for those acts which have been committed or caused in good faith. An act is said to be good faith, if it is done with due care and attention.

DISCHARGE AGAINST ADVICE

"I am leaving/taking away the patient, from the hospital against the advice of doctors. I have been informed of the risk involved and hereby release the doctors and the hospital authorities from all responsibilities for any ill effects which may result from such discharge".

Signature of the Parent/Guardian

**CONSENT FOR SURGERY, ANAESTHESIA, AND
SPECIAL PROCEDURES**

1. I hereby authorise Dr.
And/or such associates and assistants as may be
designated by him/her, to treat my
(Relationship to patient) Master/Miss/Baby
(Name of the Patient)

2. The operation and/or diagnostic procedures necessary
to treat the condition has/have been explained to me
adequately and I understand the nature of these to be
.....

.....
(Name of the Operation/Procedure/Test, in simple language).

3. I consent to the removal of the patient's Left/Right
.....
(Organ/Part) if such removal is deemed necessary during
the course of the operation. I am aware of the implications/
consequences of such removal.

4. I consent to the administration of any type of
anaesthesia, and such drugs, infusions, transfusions of
blood or blood components or any other treatment deemed
necessary or desirable in the professional judgement of the
attending medical staff.

5. The nature and purpose of the operation, the possible
alternative methods, of treatment, the risks involved and the
possibility of complications have been fully explained to me.

6. I am also aware that, during the course of the
operation, unforeseen circumstances may arise that
necessitate an extension of the original procedure(s) or a
different procedure than those initially contemplated.

7. I have also been informed that there are other risks,
such as loss of blood, infection, cardiac arrest, damage to
teeth etc., that are attendant to the performance of any
surgical or anaesthetic procedure.

8. I am aware that although the medical/paramedical staff exercise their knowledge and skill in a competent manner in the interest of the patient's welfare, no guarantee or assurances have been made to me about the results/outcome that may be obtained.

9. I consent to the photographing or video-taping, or documenting for purposes of publication of the operation(s) or procedure(s) to be performed including appropriate portions of the body for medical, scientific or educational purposes, provided the patient's identity is not revealed.

10. For the purposes of advancing medical education, I consent to the admittance of observers in the operating room.

11. I authorise the hospital authorities to suitably dispose of any tissue or part which may be removed in the course of the operation.

(Strike out the Portions/Paragraphs which do not apply)

Date: Signature:

Time: Name:

Relationship to Patient:

Witnesses:

Signature: 1) 2)

Relationship to Patient:

Date:

Time:

I have been explained all the above details by the doctor in my language I have not no doubt about this matter.

(Signature of the Patient / Authorised person)

Doctor's declaration

I certify that I have explained the nature, purpose, benefits, risks and alternatives to the proposed treatment procedure. I have also offered to answer any questions and have fully answered all such questions. I believe that the Patient/Relative/Guardian fully understood what I have explained and answered.

Signature:

Name:

Designation:

Date:

Appendix 3

The Tamil Nadu Private Clinics Establishments (Regulation) Rules, 1998

In exercise of the powers conferred by sub-section (1) of Section 14 of the Tamil Nadu Private Clinical Establishments (Regulation) Act, 1997 (Tamil Nadu Act No.4 of 1997), the Government of Tamil Nadu hereby makes the following rules, namely:

1. Short Title and Commencement

1. These Rules may be called as Tamil Nadu Private Clinical Establishments (Regulation) Rules, 1998;
2. They extend to the whole of the State of Tamil Nadu;
3. They shall come into force on the date of their notification in the Tamil Nadu Government Gazette.

2. Definitions

In these rules, unless there is anything repugnant in the subject or context

a. "Act" means the Tamil Nadu Private Clinical Establishments (Regulation) Act, 1997 (Tamil Nadu Act No.4 of 1997);

b. "Advisory Committee" means the committee constituted for the district by the Government to assist the Competent Authority in discharging his functions and it shall include, the District Siddha Medical Officer and four other persons to be nominated by the Government, one of whom shall be a professor or a lecturer from the nearest Government Medical College and two shall be Private Practitioners who are members of the Indian Medical

Association/Dental Association and one other general Medical Practitioner of the district.

c. "Appellate Authority" means the Director of Medical and Rural Health Services;

d. "Clinic" means a place where a doctor offers consultations without or with treatment by injections, minor operation, dressing etc., to the patients with no beds or one or two beds for observation. It will also include "*acupuncture Clinic*, Endoscopic Clinic, Herbal Clinic Naturopathy Clinic, Optical Centre, Oxygen Therapy Clinic, Pain Clinic, Physiotherapy Clinic or any other establishment offering treatment for illnesses or offering cure by use of medicines or any therapy.

e. "Competent Authority" means (i) in the case of Districts other than Chennai, the Joint Direct or Health Services of the district concerned; (ii) in the case of Chennai district, the Additional Director of Medical and Rural Health Services; (iii) any other person of Medical Profession so designated by the Government to perform the functions of the Competent Authority;

f. "Consulting Room" means a Clinic;

g. "Dental Clinic" means a clinic where treatment for dental ailments are given;

h. "Doctor" means and include a Registered Medical Practitioner offering consultations or treatment under allopathic or indigenous systems of medicine.

i. "Employee" means a person working in or employed by a Private Clinical establishment and includes those working on part-time, contractual, consultancy, honorary or any other basis;

j. "Form" means a form appended to these rules;

k. "Government" means the Government of Tamil Nadu;

l. "Hospital" means a place where patients are treated as in patients with facilities for admission for three or more

patients as inpatients for treatment of illness without or with surgery or conduct of delivery etc., without or with outpatient facilities;

m. "Laboratory" means a place where Bio-Medical, Clinical Pathology, Biopsy, Bacteriological or Genetic investigations or any diagnostic tests are carried out;

n. "Maternity Home" means a Hospital where deliveries are conducted, including other Gynecological operations like hysterectomy;

o. "Nursing Home" means a hospital;

p. "Polyclinic" means a clinic where more than one doctor offers consultations without or with treatment with two beds or less;

q. "Registration Certificate" means the registration certificate issued by the Competent Authority which will be valid for five years;

r. "Registered Medical Practitioner" means a person who possesses any of the recognised medical qualifications and who has been enrolled in the register of the respective Medical Council viz., Medical, Dental, Siddha, Ayurveda, Unani and Homoeopathic councils and the Board of Indian Medicine or any such Council, Board or any other statutory body recognised by the government;

s. "Rural area" means a place which is not an urban area;

t. "Scan Centre" means a place where Ultra Sound Sonogram ("T" Scan or MRI Scan) tests are done including contrast studies and/or diagnostic and/or therapeutic procedures are carried out;

u. "Section" means a section of the Act;

v. "Urban Area" means an area falling within the municipal corporation or municipal limits;

w. "X-Ray Centre" means a place where X-rays are taken or contrast studies are done;

x. Words and expressions used in the Act and not defined in these rules shall have the meanings assigned to them in the Act.

3. Minimum Requirements

The floor space and other facilities, the minimum number and the minimum qualification of the employees, the minimum equipment and other conditions required for a Private clinical establishment for providing different medical services and specialised services shall be in accordance with the norms notified from time to time by the government.

4. Application for Registration

1. Every application for registration of a Private Clinical Establishment shall be made to the Competent Authority in Form A.

2. Every such application referred to in sub-rule (1) shall be sent to the competent authority by registered post with acknowledgment due or by person.

3. The Competent Authority, or any person in his office authorised in this behalf, shall acknowledge receipt of the application for registration and assign a Registration number immediately if delivered at the office of the Competent Authority, or within fifteen days if received by post.

5. Registration Certificate

1. The Competent Authority, on receiving the application for registration shall send form B or C or D to the applicant according to the type of clinical establishment which shall be filled in and duly submitted within thirty days by the Private Clinical Establishment along with the registration fee.

2. For a Private Clinical Establishment which is a clinic or a consulting room or a polyclinic where not more than two beds have been provided for observation, the Competent

Authority may issue the registration certificate without further enquiry or inspection.

3. If more than one doctor or health professional or individual runs a single Private Clinical Establishment, only a single application form for registration shall be made by them.

4. If one doctor or health professional or individual runs more than one Private Clinical Establishment, a separate application shall be made for registration for each of the Private Council Establishments.

6. Application Form

1. Every Application form for registration shall be accompanied by an application fee of Rs.250.

2. The application fee shall be paid by a demand draft drawn in favour of "The Director of Medical and Rural Health Services, Chennai—6" payable at any scheduled bank located at Chennai.

7. Certificate of Registration

1. Upon the receipts of complete particulars in Form B or C or D as the case maybe, the Competent Authority shall, after satisfying itself that the applicant has complied with all the requirements, place the application along with the required form before the Advisory Committee for its advice.

2. The Advisory Committee shall advise the Competent Authority as to whether the applicant be issued registration Certificate. The Advisory Committee may, if necessary, inspect the premises of the applicant before giving its advice.

3. Every Private Council Establishment shall afford reasonable facilities for inspection of the place, equipment and records to the Competent Authority or the Advisory Committee.

Provided that no person who is not a registered medical practitioner shall be authorised to inspect the premises of the Private Clinical Establishment under the sub-rule(2) or sub-rule(3) by the Competent Authority.

4. Having regard to the advice of the Advisory Committee, the Competent Authority shall grant a Certificate of Registration in Form E to the applicant. One copy of the certificate or registration shall be displayed by the Private Clinical Establishment at a conspicuous place at its place of business.

Provided that the Competent Authority may grant a Certificate of Registration to a Private Clinical Establishment to provide one or more specified services depending on the availability of place, equipment and qualified employees.

5. If, after enquiry and giving opportunity of being heard to the applicant and having regard to the advice of the Advisory Committee, the Competent Authority is satisfied that the applicant has not complied with the requirements of the Act and these rules, it shall for the reasons to be recorded in writing, reject the application for registration and communicate such rejection to the applicant as specified in Form F.

6. An enquiry under sub-rule(5), including inspection of the premises of the private clinical establishment under sub-rule(2) or sub-rule(3), shall be carried out only after due notice is given to the applicant by the Competent Authority.

7. Grant of certificate of registration or rejection of application for registration shall be communicated to the applicant as specified in Form E or Form F, as the case may be, within a period of ninety days from the date of receipt of application for registration.

In the event of defects found, the same shall be intimated to the applicant and the applicant shall be asked to rectify the defects and intimate the same to the Competent Authority for reinspection by the Advisory Committee.

8. The certificate of registration shall be non-transferable. In the event of change of ownership or change of management or on ceasing to function as a Private Clinical Establishment shall apply fresh for grant of Certificate of Registration.

8. Fee for Registration

1. Every application with Form B or C or D as the case may be for registration under sub-section(2) of section 3 of the Act shall be accompanied by a fee of

a. Rs.250 for clinics located either in rural or in urban areas.

b. Rs.500 for Hospitals, Dental Hospitals, Nursing Homes, Health Centres up to 10 beds located in rural areas.

c. Rs.1000 for Hospitals, Dental Hospitals, Nursing Homes, Health Centres up to 10 beds located in urban areas.

d. Rs.1000 for Hospitals, Dental Hospitals, Nursing Homes, Health Centres with 11 to 40 beds located in rural areas.

e. Rs.2000 for Hospitals, Dental Hospitals, Nursing Homes, Health Centres with 11 to 40 beds located in urban areas.

f. Rs.1500 for Hospitals, Dental Hospitals, Nursing Homes, Health Centres with more than 40 beds located in rural areas.

g. Rs.3000 for Hospitals, Dental Hospitals, Nursing Homes, Health Centres with more than 40 beds located in urban areas.

h. Rs.2000 for Hospitals, Dental Hospitals, Nursing Homes, Health Centres with Labs or X-rays or scans located in rural areas.

i. Rs.4000 for Hospitals, Dental Hospitals, Nursing Homes, Health Centres with Labs or X-rays or scans located in urban areas.

j. Rs.1000 for Clinical Laboratories and for X-ray Centres and for Ultra Sonogram Scan Centre located in rural areas.

k. Rs.2000 for Clinical Laboratories and for X-ray Centres and for Ultra Sonogram Scan Centre located in urban areas.

l. Rs.1500 for C.T. Scan Centres and /or MRI Scan Centres located in rural areas.

m. Rs.3000 for C.T. Scan Centres and /or MRI Scan Centres located in urban areas.

n. Rs.1000 for Physiotherapy Centres located in rural areas.

o. Rs.2000 for Physiotherapy Centres located in urban areas.

p. However the maximum for any combination of two or more establishment shall not exceed Rs.5000.

2. After the issue of a Registration Certificate if there is any change in the type of that Private Clinical Establishment, such establishment shall apply with required fee for the issue of a new registration certificate incorporating the changes.

3. The fee shall be paid by a demand draft drawn in favour of "The Director of Medical and Rural Health Services, Chennai—6" drawn on any scheduled bank located at Chennai.

9. Validity of Registration

Every certificate of registration shall be valid for a period of five years from the date of its issue.

10. Renewal of Registration

1. An application for renewal of certificate of registration shall be made in duplicate in Form G to the Competent authority before ninety days of expiry of the certificate of registration;

2. The Competent Authority shall, after satisfying himself that the applicant has complied with all the requirements of the Act and these rules and having regard to the advice of the Advisory Committee in this behalf. Renew the certificate of registration as specified in Form H for a further period of five years from the date of expiry of certificate of registration earlier granted.

3. If, after enquiry and after giving an opportunity of being heard to the applicant and having regard, the advice of the Advisory Committee, the Competent Authority is satisfied that the applicant has not complied with the requirements of the Act and these rules, it shall for reasons be recorded in writing, reject the application for renewal of certificate of registration and communicate such rejection to the applicant as specified in Form F.

4. The fee payable for renewal of certificate of registration shall be one half of the fees provided in sub-rule(1) of Rule 8.

5. On receipt of the renewal certificate of registration or on receipt of communication of rejection of application for renewal, the earlier certificate of registration shall be surrendered immediately to the Competent Authority by the Private Council Establishment.

6. In the event of failure of the Competent Authority to renew the certificate of registration or to communicate the rejection of application for renewal of registration within a period of ninety days from the date of receipt of application for renewal of registration, the certificate of registration shall be deemed to have been renewed.

11. Appeal

Against any order of the Competent Authority under these rules, an appeal shall be made to the Appellate Authority within a period of thirty days from the receipt of such order.

12. Review

1. A review on the order of the Appellate Authority may be made by the Government on filing of a Review Petition by the applicant.

2. The petition for review of the orders of the Appellate Authority shall be made within thirty days of receipt of the order of the Appellate Authority.

13. Maintenance and Preservation of Records

1. Every Private Clinical Establishment shall maintain records showing the names, addresses and the qualification of all their employees.

2. In case the Private Clinical Establishment maintains records on computer or other electronic equipment, a printed copy of the record shall be taken and preserved after authentication by a person responsible for such record.

3. The Competent Authority shall maintain a permanent record of the applications for grant of certificate of registration as specified in Form I and the applications for grant or renewal of certificate of registration as specified in Form J. Letters of intimation of every change of Technical Employees and Specialists, place, address and equipment installed shall also be preserved as permanent records.

4. Every Private Clinical Establishment shall also maintain such records as may be necessary for statistical purposes in respect of various types of treatment offered by them and produce such statistics as may be required by the Competent Authority.

14. Intimation of Changes in Employees, Place or Equipment

Every Private Clinical Establishment shall intimate every change of technical employees or specialists, place, address and equipment installed, to the Competent Authority within a period of thirty days of such change.

15. Power of Competent Authority and the Government to make Public the List and Other Information

The Competent Authority or the Government may periodically make public the list of Private Clinical Establishment and the findings from the reports and other information in their possession, for the information of the public or for use by the experts in the field for research purposes was held liable.

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